National Institute on Drug Abuse

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Addicted Women: Family Dynamics, Self Perceptions, and Support Systems

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

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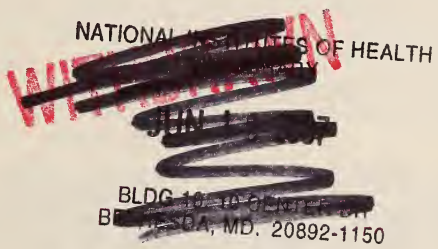

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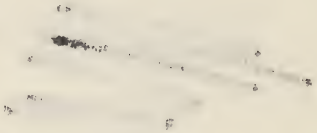

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Foreword

Over the past several years in the drug abuse treatment field, attention has been focused on the female addict and her treatment needs. Much of this attention has been the result of concern regarding the small numbers of female drug addicts coming into and remaining in treatment programs. The Services Research Branch of the National Institute on Drug Abuse funded four research/demonstration programs in 1974 to contribute new knowledge about different female addict populations, their different service needs, and the types of treatment services and programs that would be most successful in addressing those needs. These demonstration programs were the W.O.M.A.N. Center, Detroit, Michigan; WOMEN, Inc., Boston, Massachusetts; The Pregnant Addict, Addicted Mothers' Program, New York Medical College, New York; and The Odyssey House Parents Program, New York, New York.

In the past, drug treatment and research programs attempting to address the needs of female addicts had little opportunity to share and compare outcomes and findings. The treatment issues regarding the female addict were also numerous and complex, making it impossible for a single program to see all potential treatment populations. The Services Research Branch therefore arranged for the NIDA-sponsored programs to collaborate on research questions and instruments in order to develop a larger and more comparable data base.

Meetings involving key personnel from the women's demonstration projects and established leaders and experts in the field were held early in 1975 to identify and determine priorities for the issues, and to develop appropriate mechanisms and instruments required to provide a systematized research approach.

The Wayne County Department of Substance Abuse Services appeared in the best position to assume a coordinating role, since this agency had been successful in implementing a women's demonstration project, had established an affiliated agreement for research services with the Institute for Social Research at the University of Michigan, and had developed a computerized information system.

The Women's Drug Research Project (WDR) was formally implemented in mid-1975 to coordinate the collaborative network between the NIDA-funded women's programs that had been established and to assume primary responsibility for the central data collection

and data analysis system. The purpose of the project was to collect uniform data from the demonstration projects and other appropriate sources to provide a single file of baseline data.

One of the first tasks was to devise data collection tools which would facilitate a common data base. The New York Medical College staff assumed primary responsibility for developing the initial intake forms to be used for the demonstration projects and participating programs.

The NIDA demonstration programs were responsible for collecting data on their clients and assisted in the selection of appropriate comparison groups. Their dedication and willingness to collaborate made this report possible. The WDR staff was responsible for working with program managers and interviewers in five cities to collect comparison data. Health Care Delivery Services, Inc., in Los Angeles, California, and Computer Application to National Needs, Inc., in Miami, Florida, served as subcontractors, coordinating and supervising interviewers' activities in their respective cities.

Beth Reed, Ph.D., the WDR coordinator, had the primary responsibility, along with Edward Leibson, Ed.D. (former coprincipal investigator), for coordinating this project. Elizabeth Douvan, Ph.D., who worked with the Institute for Social Research, University of Michigan, served as the coprincipal investigator. Grace Damman, a NIDA consultant, reviewed the material developed and provided technical consultation.

These reports are based on issues regarding heroin-abusing women in drug treatment programs, with the data set developed by the Women's Drug Research Project (WDR). The results presented are not differentiated in terms of race, geography, social class, or type of treatment program and, in the communities selected, represent the model urban female addict in treatment, as compared to the addicted male and nonaddicted female counterparts.

The first three chapters present data on personality attributes, social support systems, and the family histories of heroin-addicted women. The fourth chapter, "Implications for Treatment and Future Research," provides practical applications and treatment suggestions as a result of the data in the preceding chapters.

It is hoped that this material will advance knowledge in the field about female addicts and their treatment needs.

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Contents

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Summary

Chapters 1, 2, and 3 of this report present analyses of three areas in the lives of addicted women--the first deals with personality, attitudes, and value measures; the second looks at support systems, current relationships with kin and friends; and the third addresses family history variables. In each chapter, women addicts are systematically compared to male addicts and/or to women of equivalent economic and educational status who presumably were not drug abusers in an effort to determine those personality variables, background experiences, and conditions of social interaction which distinguish the female addict.

Distinguishing features do emerge in each of the analyses and they form a relatively coherent pattern of characteristics of the woman addict and her life situation. The data provide a rudimentary natural history of female addiction, of the forces and life events which may predispose a young woman to addiction, and of the effect addiction may have on her life and social interaction. The pattern which emerges reveals a number of facets of the lives and orientation of addicted women:

1. Addicted women show significantly greater personal distress than comparison women. They have more physical illness and lower self-esteem than either comparison women or addicted men. The cause is not clear, although their relatively positive memories of themselves in childhood suggest that life conditions, including addiction, probably cause low self-esteem in addicted women.

2. Addicted women have fewer social supports than either addicted men or comparison women.

3. Addicted women have fewer personal resources and skills than comparison women for coping with psychological distress (i.e., depression, anger), or with practical problem situations (e.g., financial needs, child care).

4. Addicted women believe that people look down on them even more so than on addicted men. As others have noted, addicted women live in a subculture dominated by males and masculine values in which they fill secondary and dependent roles.

5. Addicted women rate themselves low on masculine traits associated with ego strength, effectiveness, and self-esteem, and at the same time rate themselves low on feminine-expressive

characteristics. While these are sex-role conceptions, they also represent areas of skill, and women addicts feel less skilled in both male and female areas than do comparison women or addicted men.

6. The family backgrounds of the addicted women are not recalled as being bleak in either material or social resources. The women addicts remember their childhoods and themselves as children with considerable positive affect. Nonetheless, addicted women report having run away from home more often, and at an earlier age, than the control women. They report heavier use of alcohol by their families, which may have contributed to a level of impulsivity and hostility in family interactions.

7. Addicted women think of themselves in childhood as having been reasonably good, skilled, and accepted by their peers. They seem to have had problems during their high school years, becoming bored and restless, experimenting with drugs, and having trouble with authorities. They are more likely than comparison women to have become pregnant during adolescence and to have left high school before finishing.

The findings summarized here have implications for program functioning and counseling practices as discussed in chapter 4.

Introduction

SAMPLES

The samples for this exploratory study consisted of a group of 202 addicted males and 146 addicted females from mixed-sex methadone maintenance and therapeutic community treatment centers in Detroit, Michigan; Los Angeles, California; and Miami, Florida. The comparison group consisted of 175 female respondents who were contacted through a branch office of the Michigan Employment Security Commission located in the same neighborhood from which many of the participating treatment centers drew their clients in Detroit, Michigan. All study participants were free to refuse to participate and all interviewees received remuneration at the completion of the interview sessions.

PROCEDURE

All respondents were given a face-to-face personal interview which lasted from 2 to 3½ hours covering a broad spectrum of areas, including self-perceptions and attitudes, social support, social history, drug use and history, and demographics. Interview schedules are available upon request from WDR at the University of Michigan. Separate coordinators and interviewing staff were hired in each city and trained by the Michigan-based Women's Drug Research Project staff. Detroit comparison women came to the WDR offices to be interviewed while, for all addicted respondents, interviewers were sent either to the treatment centers or to central intake offices.

CHARACTERISTICS OF SAMPLES

For descriptive purposes and also to establish reasonable comparability of the samples, the following demographic characteristics were examined:

(a) age
(b) highest grade completed
(c) age of youngest child
(d) age of oldest child

(e) number of children
(f) number of months employed in the last 2 years
(g) race
(h) marital status
(i) employment status
(j) religion

The mean values for the groups are used for demographic characteristics (a to f) because they are continuous variables, while for the categorical variables (g to j), percentage distributions are used.

Many of the analyses presented compare the total sample of female addicts with the total sample of male addicts. Other analyses compare only the female addicts from Detroit with the comparison women from Detroit. Therefore, the demographic data are presented for four groups: (1) addicted women, (2) addicted men, (3) comparison-group women, and (4) Detroit addicted women.

Displayed in table 1 are the mean values for each of these groups on age, highest grade completed, age of youngest and oldest child, number of children, and number of months employed in the last 2 years. Table 2 shows the percentage distributions of the groups on race, marital status, religion, and employment status.

TABLE 1.—Mean scores of subsamples on demographic characteristics

	Addicted women	Addicted men	Comparison women	Detroit addicted women
Age	25.79	27.50	25.50	25.78
Highest grade completed	11.19	11.51	12.89	11.10
Age of youngest child	6.26	6.06	1.61	5.97
Age of oldest child	9.43	9.74	2.18	8.98
Number of children	1.57	1.19	.97	1.84
Months employed in past 2 years	6.87	10.78	11.37	6.10

Note that the average age of the addicted women is just under 26 years and that on the average they have not completed high school. Over 60 percent of them are nonwhite, 19 percent are presently married (not separated), the majority are Protestant, and they are overwhelmingly unemployed (84.9 percent).

The addicted men are significantly older (around 2 years) than the addicted women, and have been employed more in the past 2 years. The men are also significantly more likely to be presently employed, although the unemployment rate for both male and female addicts is very high. The men and women do not differ in number of years of school, ages of children, race, religion, or marital status. The women do report having more children.

TABLE 2. —Percentage distributions of subsamples on demographic characteristics

	Addicted women	Addicted men	Comparison women	Detroit addicted women
Race				
White	34.8	32.7	26.4	19.2
Black	56.2	55.0	70.7	80.8
Other	8.5	12.4	2.9	0
Marital status				
Married	18.5	22.8	27.4	17.8
Separated	22.6	17.3	10.9	23.3
Divorced	15.1	9.4	8.0	6.8
Widowed	2.1	2.5	0	4.1
Never married	41.8	48.0	53.7	47.9
Religion				
Protestant	56.2	47.5	65.9	61.6
Catholic	22.6	24.3	17.3	17.8
Jewish	4.1	3.5	1.2	0
Moslem	1.4	3.5	0	2.7
Other	6.2	3.0	5.8	8.2
None	9.6	18.3	9.8	9.6
Employment status				
Full time	8.2	19.3	9.2	5.5
Part time	6.8	6.9	9.8	5.5
Unemployed	84.9	73.8	81.0	89.0

The primary differences between the men and women are that the men are a bit older and definitely more likely to have been employed recently or to be working at present.

The Detroit addicted and comparison-group women do not differ in age, race, religion, or present employment status. The comparison-group women have on the average completed high school, and they have significantly fewer and younger children than the addicted women. Since the average ages of the women do not differ, it may be inferred that addicted women started bearing children at a younger age. The comparison-group women, although presently mostly unemployed, have worked considerably more months out of the 2 years prior to testing. Marital status also differs significantly, with comparison women more likely to be presently married and less likely to be separated than addicted women.

Comparisons were also done between the Detroit addicted women and the addicted women from Miami and Los Angeles. There were no differences in age, educational attainment, ages of children, number of months employed, or present employment status. The

Detroit women do differ from the women in the other two cities in race, marital status, religion, and number of children. The Detroit women are predominantly black, while the majority of the women from the other two cities are mostly white or from some other minority group. The Detroit women appear to be less likely to have been divorced and also more likely to have never been married, although the presently married and separated groups are about equal. Fewer of the non-Detroit women are Protestant; more of them are Catholic or Jewish. These racial and religious differences most likely reflect the population compositions of the cities.

Overall, the Detroit addicted women and the addicted women from the other cities do not differ from each other on the variables which distinguish the Detroit addicted women from the Detroit comparison-group women, but they do differ from each other on variables (e.g., race, religion) which may be due to geographic differences. For this reason the Miami and Los Angeles addicted women were excluded from comparisons with the nonaddicted sample.

CHAPTER I

A Descriptive and Comparative Analysis of Self-Perceptions and Attitudes of Heroin-Addicted Women

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Knowledge and understanding of the female substance abuser has been limited by the continuation of untested assumptions and unexamined stereotypes about addiction and women. This study, using measures of attitudes, beliefs, and self-perceptions, explores some of those inadequately tested implicit and explicit assumptions about female heroin addicts.

Clinical approaches to women addicts (and other women in treatment) often reflect sexist biases (Chesler 1972; Levy and Doyle 1974; Schultz 1975). For example, psychological research indicates that therapists' criteria of mental health in women differs, in an extremely prejudicial way, from criteria for mature adults (Broverman et al. 1970). Diagnoses and treatment plans for women often reflect either male fantasies and stereotypes about women's needs and personalities or the unexplored assumption that the needs of women in treatment exactly mirror those of men (e.g., Edwards and Jackson 1975; Schultz 1975; Soler et al. 1975).

In this study, female addicts were compared with male addicts and with comparison women on measures of self-esteem, Machiavellianism, internality-externality, depression, anxiety, counterdependency (discomfort with needs and concerns for others), assertiveness, sex-role identity (masculinity-femininity), sex-role attitudes, and sex-role values.

These personality characteristics and attitudes have been considered to have critical relationships to mental health and the ability to function well. They are also closely linked with sex-role stereotypes, representing characteristics which are often expected to differentiate the sexes. Additionally, most of them have been conjectured to be consequences or causes of heroin addiction, particularly addiction in women.

Although the following discussion is not designed to present a comprehensive psychological portrait of the female addict, it does explore some very critical areas which should enrich our understanding of some causes and consequences of addiction in women, dispel some old myths, and provide some good clues for treatment of the female substance abuser.

THE MEASURES

A description of the measures and their development has been presented elsewhere (Tucker et al. 1976). The questions comprising the scales (along with a brief description of the source of the scale for those indices not developed by WDR) are available upon request from the Women's Drug Research Project through the Wayne County Department of Substance Abuse Services. Most of the scales used displayed high internal reliability as measured by Cronbach's Alpha (Cronbach 1951). The one notable exception is the Internal-External Locus of Control (I-E) Scale. The alpha for the total sample was only 0.33. Despite its low internal reliability, the scale is included because it is well established and has been used frequently in studies of addicts and nonaddicts.

All comparisons of male and female addicts use the entire sample, including subjects from Detroit, Los Angeles, and Miami. Since the control group sample was drawn from Detroit only, reported comparisons between addicted and control group women include women addicts from Detroit only. Half of the comparison group was randomly selected for inclusion in these analyses. When comparisons are made between control group women and addicted men, the same procedure will be used such that the Detroit addicted men will be compared with the same randomly selected half of the control group (nonaddicted women) sample. Although this is the most appropriate methodological approach, it does add confusion to the data presentation. For example, when we are comparing addicted women to addicted men, the mean self-esteem of the total sample of addicted women is 34.00, but the mean self-esteem of the Detroit women addicts, the group to be compared with the control group women, is 33.30.

The attitudes and self-perceptions discussed in this section are by no means independent of one another; many of them are expectably highly correlated. The intercorrelations of the major indices for each of the three sample groups, displayed in tables I-1, I-2, and I-3, will not be discussed in detail but will be alluded to when they significantly contribute to our understanding of the results. Comparisons of female addicts with the control group women, of male with female addicts, and male addicts with control group women, will be described, in turn, for each of the indices. Table I-4 compares addicted and control group women; table I-5, addicted women and men; and table I-6, control group women and addicted men. Comparative statistics (*t*-tests) are also given in the text. The description of analyses of individual indices is followed by a more general discussion of the overall findings.

TABLE I-1.—Intercorrelations of psychosocial indices: addicted women

	Sex-role values	Assertiveness	Self-esteem	Machiavellianism	Feelings of depression	Anxious feelings	Counterdependency	I-E	Masculinity	Femininity
Assertiveness	0.03									
Self-esteem	-.11	[2]0.55								
Machiavellianism	[1].19	[2]-.30	[2]-0.27							
Feelings of depression	.09	[2]-.36	[2]-.42	[2]0.27						
Anxious feelings	-.12	[2]-.27	[2]-.28	.07	[2]0.47					
Counterdependency	-.03	[2].28	[1].21	-.11	[2]-.25	-0.12				
I-E	-.09	[2]-.28	[2]-.26	.11	[1].17	.12	-0.06			
Masculinity	.03	[2].56	[2].64	[1]-.21	[2]-.35	[2]-.26	.13	-0.16		
Femininity	-.10	.02	[2].23	-.07	.05	.04	[1]-.19	-.02	[2]0.23	
Body image	-.14	[2].24	[2].39	[2].39	[1]-.17	-.15	.06	-.06	[2].37	0.09

[1] $p < 0.05$.

[2] $p < 0.01$.

TABLE I-2. —Intercorrelations of psychosocial indices: comparison women

	Sex-role values	Assertiveness	Self-esteem	Machiavellianism	Feelings of depression	Anxious feelings	Counterdependency	I-E	Masculinity	Femininity
Assertiveness	0.08									
Self-esteem	.01	[2]0.49								
Machiavellianism	.08	-.10	-0.14							
Feelings of depression	-.08	[2]-.33	[2]-.41	[1]0.17						
Anxious feelings	[1]-.18	[2]-.22	[2]-.34	.08	[2]0.47					
Counterdependency	0	[2].24	[2].31	-.11	[2]-.36	[2]-.47				
I-E	.02	[1]-.16	[2]-.21	[2].24	[2].21	.11	[1]-0.20			
Masculinity	.8	[2].39	[2].50	.08	[2]-.39	[1]-.24	.05	-0.12		
Femininity	-.02	-.06	.03	-.04	.18	.24	[2]-.44	-.07	[1]0.27	
Body image	0	.04	[2].37	-.09	[2]-.18	[1]-.18	[2].23	[2]-.22	[2].38	0.01

[1] $p < 0.05$.

[2] $p < 0.01$.

TABLE I-3.—Intercorrelations of psychosocial indices: addicted men

	Sex-role values	Assertiveness	Self-esteem	Machiavellianism	Feelings of depression	Anxious feelings	Counterdependency	I-E	Masculinity
Assertiveness	0.03								
Self-esteem	-.07	[2]0.50							
Machiavellianism	[2].28	.10	-0.13						
Feelings of depression	.07	[2].41	[2]-.39	0.09					
Anxious feelings	-.02	[1]-.17	[2]-.19	.01	[2].43				
Counterdependency	.04	[2].22	[2].26	[1]-.17	[2]-.22	-0.14			
I-E	.03	[2]-.19	[2]-.21	[2].24	[2].21	.10	-0.11		
Masculinity	-.09	[2].50	[2].58	.03	[2]-.19	-.08	.11	[2]-0.29	
Femininity	[2]-.27	-.08	[2].34	[2]-.28	-.03	.02	-.10	.04	[2]0.28

[1] $p < 0.05$.

[2] $p < 0.01$.

TABLE I-4. —Comparisons of mean scores of addicted and control group women from Detroit on psychosocial indices

	Addicted women	Comparison women	*t*	*df*	*p*
Self-esteem	33.30	40.33	6.81	159	< 0.001
Assertiveness	52.34	53.78	1.10	158	N.S.
Machiavellianism	45.96	45.26	.64	158	N.S.
Internality-externality	6.56	6.30	1.42	157	N.S.
Feelings of depression	45.21	35.83	4.74	159	< 0.001
Anxious feelings	9.51	8.10	3.46	159	< 0.001
Body image	35.06	35.01	.04	159	N.S.
Counterdependency	6.00	6.99	2.91	159	< 0.01
Sex-role attitudes I	10.89	12.43	3.53	159	< 0.001
Sex-role attitudes II	8.34	9.00	1.86	159	N.S.
Sex-role attitudes III	4.41	5.15	2.62	159	< 0.01
Sex-role attitudes IV	8.52	8.73	.65	159	N.S.
Masculinity	27.52	31.58	4.98	158	< 0.001
Femininity	32.06	34.51	3.30	158	< 0.01
Sex-role values	8.71	8.25	2.09	155	< 0.05

TABLE I-5.—Comparisons of mean scores of addicted women and men on psychosocial indices

	Addicted women	Addicted men	*t*	*df*	*p*
Self-esteem	34.00	36.87	4.12	346	<0.001
Assertiveness	51.45	54.48	3.54	346	<0.001
Machiavellianism	45.97	48.47	2.98	344	<0.01
Internality-externality	6.56	6.30	1.94	346	<0.06
Feelings of depression	46.35	40.82	4.05	345	<0.001
Anxious feelings	9.98	8.79	4.45	346	<0.001
Counterdependency	6.14	7.38	4.90	346	<0.001
Sex-role attitudes I	10.90	10.78	.39	346	N.S.
Sex-role attitudes II	8.46	7.50	4.15	346	<0.001
Sex-role attitudes V	8.38	7.92	2.61	345	<0.01
Masculinity	26.93	29.05	3.49	346	<0.001
Femininity	32.93	30.16	5.02	346	<0.001
Sex-role values	8.32	8.43	0.65	341	N.S.

TABLE I-6.—Comparisons of mean scores of control group women and addicted men from Detroit on psychosocial indices

	Comparison women	Addicted men	*t*	*df*	*p*
Self-esteem	40.33	36.93	3.86	174	<0.001
Assertiveness	53.78	53.42	.31	173	N.S.
Machiavellianism	45.26	47.28	1.87	172	N.S.
Internality-externality	6.30	6.39	.47	172	N.S.
Feelings of depression	35.83	39.20	2.02	173	<0.05
Anxious feelings	8.10	8.76	1.99	174	<0.05
Counterdependency	6.99	7.33	1.02	174	N.S.
Sex-role attitudes I	12.43	11.23	2.76	174	<0.01
Sex-role attitudes II	9.00	7.72	4.05	174	<0.001
Masculinity	31.58	28.75	3.73	173	<0.001
Femininity	34.51	31.53	4.22	173	<0.001
Sex-role values	8.25	8.52	1.20	170	N.S.

SELF-ESTEEM

Substance abuse literature consistently indicates that heroin addicts have poor self-images and that their regard for themselves and their sense of self-worth is considerably lower than that of nonaddicts (Arnon et al. 1974; Gossop 1976; Kilman 1974). General psychological research also indicates that women have lower self-esteem than men (Bardwick 1971; Gurin et al. 1960; Rosenkrantz et al. 1968). As a consequence, women addicts would be expected to have lower self-esteem than both male addicts and comparison women. The data confirm this hypothesis. The addicted women are lower in self-esteem than the addicted men [t (346)=4.12, $p < 0.001$] and lower in self-esteem than the nonaddicted women [t (159)=6.81, $p < 0.001$]. Additionally, the addicted men score lower in self-esteem than the comparison women [t (174)=3.86, $p < 0.001$].

While substance abuse literature suggests that a woman must be much more deviant than a man to use heroin, the relatively low self-esteem of the female addict is often attributed to circumstances--such as prostitution--which surround addiction, rather than addiction per se (e.g., Densen-Gerber et al. 1972; Domantay 1973; Nyswander 1956). However, our finding that male addicts are lower in self-esteem than comparison women suggests that addiction itself, and not accompanying behaviors, contributes most heavily to low self-esteem among female addicts.

Both the male and female addict groups were tested at a time near to their entry into treatment. In all probability self-esteem would be at a particularly low level at this time, in that admission of the need for treatment, as well as initial treatment processes aimed at stripping away defenses, may accentuate low self-esteem.

The drug subculture is at least as male oriented as the dominant culture (File 1976; Levy and Doyle 1974). Women, and the roles relegated to them, are of secondary status (Hughes et al. 1971). That female addicts display comparatively lower self-esteem than the male addicts suggests that their self-images suffer from this double burden, of the prejudices experienced because they are women and because they are addicts (Miller et al. 1973). Treatment programs using confrontation techniques may exacerbate rather than alleviate this problem for women. A woman who has little sense of her own self-worth may also feel she is not worth the effort of treatment.

Hence, lower self-esteem among women addicts is best viewed as a predictable response to the attitudinal context in which they find themselves; it should not necessarily be taken as an indication of greater "sickness" and/or lower rehabilitation potential.

ASSERTIVENESS

The Assertiveness Scale was designed to measure the ability to express one's opinions and stand up actively for one's rights without aggression or hostility, while remaining sensitive to the needs of others. This particular skill has generally been considered to be lacking in women (e.g., Bardwick 1971).

Although our data show no significant differences in assertiveness between addicted and comparison women, addicted women are significantly less assertive than addicted men [t (346)=3.54, $p < 0.001$], while comparison women and addicted men do not differ in mean assertiveness scores.

These data suggest that assertiveness training may be a necessary component of treatment programs for addicted women, if women are to be able to advocate successfully for themselves in a mixed-sex treatment context.

MACHIAVELLIANISM

The Machiavellianism Scale is a measure of the willingness to manipulate others and the perception of others as basically manipulative and unkind (Christie and Geis 1973). According to Christie and Geis, it is not all bad to be somewhat Machiavellian and individuals who are higher in Machiavellianism have a realistic sense of how to manage their social environments. On the other hand, being very Machiavellian does indicate some disregard for the feelings and concerns of others. The Machiavellianism Scale was included in this study as a test of the popular notion that addicts are extremely manipulative (Chein et al. 1964). This notion is disconfirmed by the data--neither female nor male addicts are significantly more Machiavellian than the comparison women. Addicted men, however, are significantly more Machiavellian than addicted women [t (344)=2.98, $p < 0.01$].

Because studies by Christie and Geis indicate that individuals high in Machiavellianism almost always come out ahead, addicted women in mixed-sex programs or addicted women being treated by male therapists may be at a severe disadvantage.

INTERNALITY-EXTERNALITY

One factor or subscale of the Multidimensional Internal-External Locus of Control Scale (Gurin et al. 1969), personal control, was examined for this study. These items, all worded in the first person, indicate the extent to which an individual believes that he/she controls events in his/her own life as opposed to control by external forces, including fate or chance.

Substance abuse literature suggests that addicts feel very little control over their own lives and therefore turn to drugs as a means of escape (Pittel 1971). Researchers have theorized that the process of drug taking and its related behaviors gives the addict a sense of control. For example, Berzins and Ross (1973) found both male and female opiate addicts at Lexington to be more internal--to have a higher sense of personal control--than a comparison group of college students.

In our data, there were no significant mean score differences between addicted women and men nor between addicted and comparison women on this scale. There were, however, borderline differences between male and female addicts, with the addicted women being more external, reporting less sense of personal control [t (346)=1.94, $p < 0.06$].

It is most likely true that women addicts do in fact have less control over their lives than men addicts, since they are more likely to be responsible for children and less likely to be employed (Eldred and Washington 1975; Ellingwood et al. 1966). Furthermore, they tend to be less assertive than male addicts, which may reinforce their sense of relative powerlessness. This borderline difference is best viewed from the perspective of the objective constraints in the lives of women addicts; they have less sense of control because they have less control.

That the addicted woman does not differ from the comparison woman may indicate perceptions of control have less to do with addiction per se than with socioeconomic status and education. This index is the least stable of any used in this study and the results should be most cautiously interpreted.

DEPRESSION

The measure of depression in this study has been used in national surveys (e.g., Gurin et al. 1960). It has been shown to be highly reliable and valid, and is considered to be good for use in a variety of populations (Radloff 1977).

It was selected because it is not considered to be a diagnostic tool or a measure of pathology. Any of the symptoms in the scale could be experienced and reported by psychologically healthy individuals, with more depressed persons tending to report more of the symptoms at any one testing time. Unlike measures of psychopathology, which are expected to remain more stable over time, scores on this scale may be expected to vary considerably, fluctuating in response to life events. It was chosen also because it appears to include fewer physical symptoms than other measures of depression. Substance abuse and withdrawal may create physical symptoms which, although they may be similar, ought not to be considered as symptoms of depression.

Women, generally, report being more depressed than men (e.g., Gove and Tudor 1973; Silverman 1968). This has been attributed to response biases--the greater willingness of women to admit to depressive symptoms (Cooperstock 1971; Phillips and Segal 1969) and to the realities of women's lives. That is, given their lot in life they ought to be more depressed.

The addicted women in this study are, in fact, considerably more depressed than both addicted men [t (345)=4.05, $p < 0.001$], and comparison women [t (159)=4.74, $p < 0.001$]. Addicted men and comparison women also differ significantly in reported mean levels of depression, with the addicted men reporting greater depression than comparison women [t (173)=2.20, $p < 0.05$].

As with the self-esteem results, we must conclude that addiction itself results in reports of more or greater depressive symptoms. If this were not the case, we would expect the addicted males to show less, rather than more, depression than the control group women.

On the other hand, addicted women are overwhelmingly more depressed than the other groups. This finding should not be taken lightly, particularly since the individuals composing the other two groups have serious life problems--the men are substance abusers just entering treatment and most of the women are unemployed and actively looking for work. Response biases may be involved in this result but it is unlikely that women addicts are simply more willing to complain. Again, we must look to their life circumstances. The data on their social relationships and on their life problems indicate that they have more about which to complain (chapter 2). This finding may also be linked to the data on self-esteem, and the factors causing depression and low self-esteem may be similar. The addicted women in this sample have all recently entered mixed-sex treatment programs. Critiques of traditional treatment programs have suggested that staff are less likely to expect women to successfully complete treatment and may, in fact, implicitly communicate this to the women (Levy and Doyle 1974). The women may be at a low point when they enter, so confrontation and forced self-examination in conjunction with weakened defenses may leave women feeling discouraged and hopeless. They may have been forced to relinquish their children, and have relatively fewer social supports (chapter 2). It also has been suggested that women addicts are treated like "whores" whether or not they have ever prostituted to earn money to support their habits (Schultz 1975). They are also less likely to be employed (or to have hopes of employment) than male addicts. As we shall see later, they feel mistrustful of women and abused by men. They are also well aware of the negative societal response to women substance abusers and over half of the addicted women agree that "women addicts are worse than men addicts." A good number of these women may have internalized this negative appraisal and their lower self-esteem and greater depression may reflect awareness and/or acceptance of these attitudes. In all, their situations are at best dreary and at worst shockingly depressing. If they did not appear more depressed

than male addicts we might wonder what was wrong with them. Less depression could constitute an unnatural response to a difficult situation.

One study (Fisch et al. 1973) found that more highly depressed clients in a methadone program tended to show greater improvement than low-depression clients; in fact, the low-depression clients tended to get worse in conjunction with therapy. On the other hand, highly depressed clients tended to be more likely to drop out from treatment. This suggests that the greater depression of the female addicts may make them good candidates for successful therapeutic intervention, provided that the program makes intensive efforts to engage them and keep them in the program during the initial phases of treatment. So their heightened depression may be a hopeful sign if it is dealt with appropriately.

ANXIETY

The anxiety index used in this study was chosen on the basis of criteria similar to those for selection of the depression index. Although the scale is comprised of only four items, the Cronbach's Alpha for the entire sample is 0.64, indicating relatively high internal reliability.

The items on this well-validated scale are reports of physical symptoms often associated with anxiety. These symptoms may of course also be associated with herion withdrawal. They are indicators of felt distress, whether physiologically or psychologically induced. Tucker and Colten (1978) have shown that reports of these symptoms by addicted women are mediated by social support, suggesting that they may be socially alleviated even if they are physiologically caused.

Women addicts are more anxious than men addicts [t (346)=4.45, $p < 0.001$] and more anxious than comparison women [t (159)= 3.46, $p < 0.001$]. Addicted men also report greater anxiety than comparison women [t (174)=1.99, $p < 0.05$].

As with the depression results, it appears that the process of addiction and/or entering treatment affects reports of anxiety, since both male and female addicts report significantly more anxiety than the control group. The addicted women again are reporting more or greater symptoms than the addicted men, a result that would not be expected if the scale were tapping only physical consequences of substance abuse or withdrawal. This should be taken as a sign that they are experiencing greater discomfort.

As discussed in chapter 2 of this volume, the addicted women face more problems and seem to have fewer social supports with which to face them. Their anxiety may be a consequence of their problems and isolation.

The greater anxiety of women addicts may also be due to their fears that they will be unsuccessful in the program. Their lower self-esteem and lower sense of control over their lives supports this notion. Additionally, we do not know what treatment programs do (or do not do) to make women feel that they can be successful. It is possible that the initial phases of treatment in most programs have not been designed to alleviate the fears and anxieties of women clients.

A certain amount of anxiety may not be all bad; it may serve as a motivator. One study did find that the most anxious clients were also the most successful clients (Levine et al. 1972). This study was done with a group of addicted males so it is possible that the high-anxiety male clients were still not as anxious as female clients would be.

Very high levels of anxiety have been shown to cause decrements in performance (Sarason et al. 1960; Sarason 1961). We suspect that addicted women may get trapped in the proverbial vicious cycle, with heightened anxiety leading to poorer performance and lower self-esteem which then again lead to greater anxiety. Any successful intervention strategy must attend to the higher anxiety level of these women.

BODY IMAGE

The Body Image Scale, developed by WDR, is designed to measure the degree to which women feel positive about their bodies. It was included in this study because of the common stereotype that addicted women hate their bodies, often presumed to be a consequence of prostitution experiences and the physical debilities which result from continued heroin use (e.g., needle scars, collapsed veins, sores) (Densen-Gerber 1972; Levine 1974).

Contrary to what would have been expected on the basis of other writings, the addicted and comparison women do not differ significantly in their scores on the Body Image Scale; they report virtually identical amounts of positive feelings toward their bodies. Both groups score toward the positive end of the scale.

This finding suggests that feelings about their bodies are not as great an area of concern for addicted women as has been believed. Other life problems are probably more salient and more influential in determining self-esteem, depression, etc., and are probably more critical areas for the focus of treatment programs.

COUNTERDEPENDENCY

The Counterdependency Scale, developed by WDR, measures the extent to which an individual rejects, or is uncomfortable with, needs for others and the extent to which she/he wishes to be less concerned with the welfare of others.

The addicted women are less counterdependent than the comparison women [t (159)=2.91, $p < 0.01$] and less counterdependent than the addicted men [t (346)=4.90, $p < 0.001$]. The scores of comparison women do not differ significantly from the scores of the addicted men on this scale.

We cannot say how much counterdependence is enough counterdependence, so these results cannot be discussed in evaluative terms. The addicted women report more comfort with their needs and concerns for others. Chapter 2 describes addicted women as having fewer significant relationships. Their lack of counterdependence may reflect their lack of dependency-based relationships. It may also reflect a healthy acceptance of their greater dependence on others and more openness to relationships. If this is the case, treatment programs could be designed to capitalize on this openness.

A note of caution in interpreting these results. First, the scale includes only three items and should therefore be interpreted warily. Secondly, some of the questions in this scale were "double-barreled" questions--e.g., "I wish I didn't worry so much about the people who are close to me." In order to report that as being very true of oneself, one first must have close relationships and must then have the energy to worry about those people. The addicted women do have so many problems of their own to worry about that they possibly cannot afford to worry about others.

SEX-ROLE ATTITUDES

The sex-role attitudes questions developed by WDR were factor analyzed, resulting in five primary factors or clusters of attitudes relating to sex roles. Comparisons of the group scores on each of these factors will be described along with some comparisons on individual items of particular importance.

Factor I: Traditional sex-role ideology. The items in this index are concerned with what respondents see as the appropriate roles of men and women in the home and the workplace. A lower score indicates adherence to traditional sex-role ideology--women should stay home, keep house, and rear children while men should work. A higher score indicates a more liberated or feminist perspective, a greater belief in the equality of the sexes, and acceptance of greater flexibility in sex roles and tasks relegated to men and women. Although this index includes only four items, the Cronbach's Alpha is a respectably high 0.66.

The addicted women are significantly more traditional in their sex-role attitudes than the comparison women [t (159)=3.53, $p < 0.001$]. In fact, they are equally as traditional as the male addicts; there are no significant differences in the male and female scores on this index. Comparison women are less traditional than addicted men [t (174)=2.76, $p < 0.01$].

Addicted women, then, share with addicted men traditional expectations for sex-based division of labor. Although these old attitudes are beginning to be abandoned in the mainstream culture, we find the addicted women adhering to them. This is particularly interesting since they may be less likely to be in a position to be independent of men, but may find it more necessary to breach traditional sex-role boundaries in order to survive. This result reaffirms their strong dependence on men and may also reflect a great desire to defer to the wishes of the men with whom they associate.

The traditional nuclear family, with the male breadwinner and the female housewife, is partially a fantasy/myth, based upon the experience of middle-class families in the 1950s and 1960s. This family configuration is no longer the predominant one in our society; it is becoming economically impossible and psychologically infeasible for the majority of American women. It may be even less accessible to addicted women. It is possible that their responses indicate a desire to live in a manner which has been held up as the one true model for successful American "ladies." In other words, these women may wish very much to live what they see as a "normal" life.

Factor II: Women are strong and men are weak. A higher score on this cluster of items indicates a greater belief that men need to be taken care of while women can manage and absorb more hurt than men. This three-item factor has a Cronbach's Alpha of 0.45 for the total sample, so the results should be cautiously interpreted.

Both addicted women and comparison women score higher than addicted men [t (346)=4.15, $p < 0.001$; t (174)=4.05, $p < 0.001$, respectively]. There were no significant differences between the scores of addicted and comparison women.

The mean scores of both groups of women show that they tend to agree with the statements in the index. Agreement may be taken as an indication of infantilization of men, a belief that men (underneath all the swagger), are very needy creatures or, at least, not very resourceful. Another interpretation of these items is that they indicate a belief in the resourcefulness of women, although this is unlikely given the low self-esteem of the women addicts.

The results suggest that both samples of women are somewhat disappointed with men. The men in their social networks may be needy or, at least, unwilling or unable to be helpful to the women or to serve as a buffer for the women's hurts.

It is encouraging to note that addicted women see themselves as ultimately more resilient than men, although it does not speak well of the men they know--their compatriots in treatment programs, for example.

Factor III: Comfort with women. These items indicate the extent to which a woman finds it easy to be with other women and share her feelings with them. The comparison women score significantly higher on this index than the addicted women [t (159)=2.62, p 0.01]. A look at the mean scores, 5.15 and 4.41 out of a possible 8 for the comparison and addicted women respectively, does show that neither group has strong positive feelings toward other women, but neither do they have the strong negative feelings about relations with other women that they have about the responses they receive from men.

As reported in chapter 2, addicted women are generally more isolated and have more frequently than comparison women experienced discomfort or lack of support from others. The general picture suggests that treatment programs should be particularly attuned to fostering supportive relationships among women.

Factor IV: Men are not nice to women. This index is a measure of the way women feel that men treat them. A high score indicates feelings that men treat women very badly and with little respect. The addicted and comparison women do not differ in their mean scores on this index.

The agreement and distribution of responses for both groups is striking (table I-7). Approximately 70 percent of both groups of women agreed with the item, "Men are more interested in my body than me as a person." For the item, "Most men don't take women seriously," the corresponding figures were 72 percent and 75 percent. Similarly, over 83 percent of the addicted women, and over 81 percent of the comparison women agreed with the item, "Women are more badly used than men."

Both groups of women are all too clearly stating that they feel used and abused by men. Schultz (1975) has suggested women in treatment experience a perpetuation of street roles. These data suggest that the perception of mistreatment of women generalizes well beyond the street roles associated with drug use. It may have serious implications for women who may have male therapists or are in mixed-sex treatment groups.

These data are even more disturbing when we look at responses to the item, "The only way for women to survive is to have men protect them." The vast majority of both addicted (82.2 percent) and comparison (78.5 percent) women agreed with this statement; there are no significant differences between the groups.

Addicted women (and comparison women, too) then feel that even in view of the abuse or because of the abuse they need men to protect them.

Factor V: Attitudes toward women addicts. The following items were included in this critical index:

TABLE I-7.—Comparisons of responses of addicts and control group women on attitudes about men (in percent)

"Men are more interested in my body than me as a person."

	Disagree a lot	Disagree a little	Agree a little	Agree a lot
Addicted women	16.4	12.3	35.6	35.6
Comparison women	11.4	19.3	28.4	40.9

"Most men don't take women seriously."

	Disagree a lot	Disagree a little	Agree a little	Agree a lot
Addicted women	6.8	20.5	43.8	28.8
Comparison women	9.1	15.9	39.8	35.2

"Women are more badly used than men."

	Disagree a lot	Disagree a little	Agree a little	Agree a lot
Addicted women	4.1	12.3	37.0	46.6
Comparison women	4.6	13.8	33.3	48.3

"The only way for women to survive is to have men protect them."

	Disagree a lot	Disagree a little	Agree a little	Agree a lot
Addicted women	4.1	13.7	28.8	53.4
Comparison women	9.1	12.5	20.5	58.0

1. "Women addicts are worse than men addicts."

2. "Men look down on women addicts more than they do on men addicts."

3. "Women look down on women addicts more than they do on men addicts."

Overall, addicted women, more than addicted men, report that women addicts are worse and are looked down on more [t (345)= 2.61, $p < 0.01$].

A look at the individual items enhances our understanding of these results (table I-8). Addicted women are significantly less likely than addicted men to agree that, "Women addicts are worse than men" [χ^2 (3)=19.7, $p < 0.001$]. Still, more than half of the women (55.5 percent) and more than two-thirds of the men (67.8 percent) agree. (This does not mean that those who disagree necessarily think men worse; they may see them as equally bad.)

Although there are no significant differences between the responses of men and women to the item, "Men look down on women addicts more than they do on men addicts," 89.8 percent of the women and 88.6 percent of the men agreed with this statement. So, while a slight majority of the addicted men and women feel that women addicts are worse, a whopping majority feel that men look down on women addicts more.

Also, the vast majority of addicted women (69.2 percent) and addicted men (72.8 percent) agree with the statement, "Women look down on women addicts more than they do on men addicts." Although both figures are high, women are significantly less likely to agree [χ^2 (3)=13.2, $p < 0.01$] and more likely to strongly disagree (15.1 percent of women versus 6.9 percent of men).

Many writers in the field have referred to the self-hatred of women addicts. These results indicate that, although more women than men addicts say addicted women are worse, what may have been called "self-hatred" is simply a recognition of the fact that others, particularly men, more strongly disapprove of addiction in women.

There is, in reality, no reason why female addicts should be condemned more than male addicts; they share the same problem of addiction. And yet, they are treated as if they are worse. The data show that this is not paranoia on the part of these women--the men also acknowledge the situation.

The extreme isolation of addicted women (chapter 2), their low self-esteem, and their high depression, may all be linked to these reports of attitudes toward women addicts. Both men and women say that women addicts are viewed with disfavor--rejects among a community of rejects. It appears that addicted women may be censured because they are women.

TABLE I-8.—Comparisons of responses of addicted women and men on attitudes toward women addicts (in percent)

"Women addicts are worse than men addicts."

	Disagree a lot	Disagree a little	Agree a little	Agree a lot
Addicted women	25.3	19.2	18.5	37.0
Addicted men	8.4	23.8	27.7	40.1

χ^2 (3)=19.7, $p < 0.001$

"Men look down on women addicts more than they do on men addicts."

	Disagree a lot	Disagree a little	Agree a little	Agree a lot
Addicted women	4.1	6.2	19.9	69.9
Addicted men	3.5	8.0	25.4	63.2

"Women look down on women addicts more than they do on men addicts."

	Disagree a lot	Disagree a little	Agree a little	Agree a lot
Addicted women	15.1	15.8	24.7	44.5
Addicted men	6.9	20.3	38.1	34.7

χ^2 (3)=13.2, $p < 0.01$

MASCULINITY, FEMININITY, AND ANDROGYNY

The development of the New Sex-Role Questionnaire, the scale used to assess masculinity, femininity, and androgyny, is described in an earlier WDR paper (Colten 1977). It is derived, for the most part, from the Personal Attributes Questionnaire (Spence et al. 1974), which has been one of the two most frequently used measures of sex-role attributes. Masculinity and femininity are treated in this scale as reports of internal psychological attributes and tendencies. The scale measures the self-concept of individuals with respect to sex-role-related attributes.

The assumption underlying the scale is that masculinity and femininity are independent dimensions. The presence of one in an individual does not preclude the presence of the other, so persons may be high in both masculinity and femininity. (Until

recently, masculinity and femininity were treated as opposites, as negatively related ends of a bipolar dimension.) A further assumption is that androgynous individuals, those having both masculine and feminine attributes, are generally better off than those having only one or the other. The masculinity items are items that could be considered to be agentic or instrumental (e.g., assertive, competitive), while the femininity items are more expressive or communal (e.g., kind, warm).

In common usage of the scale, the group scores are split at the median, such that individuals scoring above the median on the masculinity index are classified as high masculine, while those scoring below the group median are classified as low masculine. The same process is used with the femininity index, so that individuals are also classified as high feminine or low feminine. Masculinity and femininity classifications are then crossed, resulting in four possible categorizations of individuals: masculine (high masculine, low feminine), feminine (high feminine, low masculine), androgynous (high masculine, high feminine), and undifferentiated (low masculine, low feminine).

Research conducted using this classification schema indicates that self-reported sex-role attributes are of great value in predicting and understanding variations in other characteristics, attributes, and behaviors (Bem 1977; Spence et al. 1975). Androgynous individuals are not sex typed and not limited in behavior or orientation by sex-role stereotypes. They should be most able to behave in a way which is appropriate to a situation, rather than attempting to keep their behavior consistent with sex-role stereotypes. In other words, they can be both instrumental and expressive and thus have the widest range or repertoire of social skills. Masculine individuals, on the other hand, may be inhibited from acting in ways which are stereotypically feminine--they may be unable to cry, to express their feelings, or to offer warm support to others. Conversely, an individual with a feminine self-concept, while being able to engage in these expressive activities, may not be able to, for example, be aggressive when appropriate. They do not see themselves as having the capability to be highly instrumental. Although not sex typed, individuals classified as undifferentiated appear to have problems. These individuals who report themselves low on both masculinity and femininity may have severely constricted behavior patterns and abilities. Spence et al. (1975) have shown undifferentiated individuals to be lower in self-esteem than either sex-typed or androgynous persons.

Although the scale is most often used as an index of androgyny, it is quite reasonable to look at an individual's masculinity and femininity scores separately before combining them into an androgyny index.

Masculinity

Comparison women are higher in masculinity than both addicted women [t (158)=4.98, $p < 0.001$] and addicted men [t (173)=3.73,

$p < 0.001$]. Addicted men are predictably higher in masculinity than addicted women [t (346)=3.49, $p < 0.001$].

Two aspects of these results should be noted. First, the addicted women are lower in masculinity than the other two groups. Although, a priori, we would expect a group of women to be lower in masculinity than a group of men, the differences between the two groups of women is quite telling. Masculinity scores are significantly positively correlated with self-esteem, assertiveness, and body image, and are significantly negatively correlated with depression and anxiety (table I-1). Therefore, the greater the masculinity score, the better off an individual appears to be. This is not surprising since many of the masculinity items are quite evidently competence items--e.g., stands up well under pressure, can make decisions easily, independent, never gives up easily. They are also reflections of sense of self-worth, which is indicated by very high correlation with self-esteem scores. Thus, addicted women report themselves to be lacking in some critical social skills which strongly relate to other measures of well-being.

The second interesting aspect of these results is that the addicted men are significantly lower in masculinity than the comparison women. It is hard to imagine that these men are less masculine or "macho" in the stereotypic sense. These items all reflect positive instrumental skills, which these men evidently feel that they lack.

Femininity

Comparison women score higher in femininity than addicted women [t (158)=3.30, $p < 0.01$] and higher than addicted men [t (173)= 4.22, $p < 0.001$]. Addicted women are higher in femininity than addicted men [t (346)=5.02, $p < 0.001$].

The feminine, expressive skills, then, are also skills that the addicted women have less of than comparison women. They see themselves as being less able to be kind, understanding, and nurturant toward others. Again, this does not mean they are less feminine, but simply that they perceive themselves as having fewer positive expressive skills.

Among the sex-role items in the questionnaire were four items specifically related to sex-role socialization:

1. "I often wished I was a boy."

2. "I never noticed any important differences in the way adults treated boys and girls and what they expected of them."

3. "I thought that, overall, girls had a better deal than boys did."

4. "I felt that the people who raised me expected me to do more work or to behave better than they would have if I had been a boy."

There were no differences between addicted and comparison women in their responses to these items, which suggests that the devaluation of expressive or feminine attributes is a more recent phenomenon in the lives of the addicted women. The necessities of their lives may push them to downplay their expressive qualities, qualities which may stand in the way of getting what they need.

Androgyny

Comparisons between groups on the androgyny categorization are problematic. Spence et al. (1974) and other researchers using the instrument from which this one was derived usually split the scores within a sample at the median to get the high/low groups. When they make comparisons between samples, they have suggested taking the mean of the medians of the groups as the criterion point. Because comparisons are being made here using all the addicted women, all the addicted men, a subsample of the Detroit addicted women and a subsample of the Detroit addicted men, plus a random half of the comparison group, it would be inappropriate to take the mean of the medians of all of those groups since some are simply subsets of others. Therefore, the mean of the medians used here was the average of the median scores of all the addicted women, all the addicted men, and the random half of the comparison-group women. For the masculinity scale, this meant that all respondents with scores of 29 or below were classified as low masculine, while those with scores of 30 and above were high masculine. Similarly, with the femininity scale, respondents scoring 32 or below were low feminine, while those with scores of 33 and above were classified as high feminine.

The percent of individuals in each of the groups falling into the four categories is displayed in table I-9. To be noted particularly is the high percentage of comparison-group women who are androgynous and the high percentage of addicted men who are undifferentiated.

TABLE I-9.—4-way classification of addicted women, addicted men, and comparison women (in percent)

	Undifferentiated	Masculine	Feminine	Androgynous
Addicted women	28.8	11.6	34.9	24.7
Addicted men	40.1	27.2	11.9	20.8
Comparison women	12.6	16.1	21.8	49.4

There are significant differences between the addicted women and the addicted men [χ^2 (3)=34.48, $p < 0.001$] and between the

Detroit addicted women and the comparison group women [χ^2 (3)=14.94, $p < 0.01$].[1]

These androgyny scores were presented primarily because the scale is most commonly used in this fashion. We feel that the more interesting results are in the comparisons of scores on the masculinity and femininity subscales. It is most important to note that both male addicts and female addicts report feeling a lack of these attributes or skills.

Others have suggested both that women addicts are overly masculine and that they are overly feminine (depending upon the perspective of the writer); in other words that they display improper sex-role identification. These data demonstrate that both of these hypotheses are to be discounted. If anything, women addicts are neither masculine enough nor feminine enough, a problem which is even greater for addicted men.

SEX-ROLE VALUES

The Sex-Role Values Scale, developed by WDR, is designed to be a measure of the value individuals place on instrumental as opposed to expressive modes of behavior. Actually, the dichotomy it is intended to tap is a bit stronger; it is asking respondents whether it is generally better to be "a tough cookie" or "an old softie." A higher score indicates responses endorsing the more masculine, less emotional mode.

The addicted women score significantly higher on this scale than do the comparison women [t (155)=2.09, $p < 0.05$], but their scores do not differ significantly from those of addicted men. The addicted men do not score significantly higher than the comparison women.

Addicted women, then, place greater value than comparison women on independence from the feelings and demands of others. This is interesting since addicted women are less masculine than the comparison women (as are the addicted men).

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[1]It is encouraging to note that many fewer addicted women than addicted men fall into the undifferentiated group. Unfortunately, these data are possibly somewhat skewed since we have lumped two groups of women with one group of men, meaning that the split point between high and low femininity may be somewhat high for the average group of men. This implies not that more of the addicted men might fall into the masculine group, but rather that they might fall into the feminine group. Therefore, addicted men also experience a lack of a sense of having instrumental skills.

In opposition to the studies on alcoholism which suggest that women alcoholics are unable to meet deep-seated standards of femininity (Wilsnack 1973), these results suggest that female addicts feel their lives would be better if they were less traditionally feminine, less responsive to the feelings of others. In other words, the women would like to be as independent, assertive, and Machiavellian as the men they know. Even more than the comparison women, they are trapped by a system which devalues interpersonalism.

SUMMARY AND DISCUSSION

Overall, addicted women as compared to comparison women appear to be lower in self-esteem, higher in reported symptoms of depression and anxiety, more open to relationships (less counter-dependent), lower in masculinity and femininity, and higher in assertiveness. They have more traditional standards for role division between the sexes, while sharing with the comparison group a clearly negative view of men.

The self-esteem, depression, anxiety, and masculinity and femininity scores fall into a rather predictable pattern. This pattern may be attributed to the confluence of several factors: recent entry into treatment with its concomitant pressures; the fact that entry into treatment probably indicates that the woman's situation has reached a nadir or crisis point; the isolation and lack of social support experienced by addicted women; and the greater number of life problems reported by addicted women. Additionally, the overwhelmingly negative societal attitudes toward women addicts are clearly perceived by these women and reflected in their attitudes toward themselves.

On the positive side, addicted women are more comfortable with dependency, are no more Machiavellian, and are as assertive as the comparison women. They do evidence social skills and a willingness to become involved with others.

Compared with addicted men, women addicts are lower in self-esteem, higher in anxiety and depression, less assertive, and have less sense of control over their lives. They are less Machiavellian, less counterdependent, have less traditional sex-role attitudes, and share negative attitudes toward women addicts. This general picture indicates that they may be at a disadvantage in programs which are not particularly responsive to the needs of women who are addicted.

The women are more interested in and open to interpersonal relationships than the men, and also more responsive to the feelings of others. As evidenced by their scores on the Sex-Role Values Scale, these women have been taught to downplay and devalue these aspects of themselves. This is probably due both to the attitudes of the men they come into contact with, and to the realities of surviving in the drug culture. Treatment

programs could foster those strengths and emphasize their value while at the same time training women in the skills which they may lack.

In large part, the measures on which the addicted women do not appear to be as well off are "reactive" measures, measures of self-perception, and feelings such as self-esteem, depression, and anxiety which are certainly responsive to situational stress. As Douvan (1970) points out, women in general tend to assess themselves and derive their sense of self-worth from the responses of others. Attitudes toward and perceptions of addicted women are strikingly negative. These women simply mirror these attitudes in their own perceptions of themselves.

Their symptoms of anxiety and depression, low self-esteem, and lack of confidence in their instrumental and expressive skills, in addition to their many health, economic, and interpersonal problems may, in fact, be assets in the treatment situation. We might expect that many of these women would be very open to drastic change, given the proper combination of facilities, program design, and staff attitudes.

SUGGESTIONS

The results presented here constitute only a first step toward understanding the female addict, her strengths, her problems, and the solutions to those problems.

Although we have proffered source descriptions of the modal addicted female, we have not yet undertaken the task of examining variations between women addicts. The attitudes and self-perceptions discussed here may vary considerably according to demographic characteristics such as ethnicity, age, and length and degree of substance abuse. They may additionally be affected by and also affect a woman's social relationships, her interactions with other adults, and with her children.

We also do not yet know which of these characteristics are related to or may be predicted from a woman's past history, which are definitely related to her present situation, and which of them may be the result of both past and contemporaneous experiences.

Further, as has been suggested here, some of these aspects appear to cluster together. By identifying these clusters through the formation of second-order indices, we may be able to identify a variety of types of women addicts, each of whom have different needs and may respond best to different kinds of treatment.

Careful study of a variety of treatment modes and settings, taking into account these personality factors along with past history and present social situation, also needs to be done to develop greater understanding of the addicted female.

In the meantime, it is most important to remember that addicted women are not exactly like all other women, and more critically, they are not just like addicted men. Their problems, perceptions of themselves, their attitudes, and, consequently, their needs must be considered in any attempts to assist them in treatment.

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CHAPTER II

A Descriptive and Comparative Analysis of the Social Support Structure of Heroin-Addicted Women

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When viewing the addictive process and its psychological as well as physical consequences, it seems apparent that social relationships figure predominantly in the phenomenon. It is well known that individuals rarely begin using drugs in isolation (Brown et al. 1971; Chambers et al. 1970; Chambers et al. 1968; Ellinwood et al. 1966; Powell 1973). One might also surmise that the act of staying on drugs requires the support of at least a few key persons for the provision of financial, physical, and practical aid when needed.

Apart from the drug initiation studies, few have investigated other domains of supportive social relationships related to drug use. Since there is widespread belief, with some empirical support (Douvan and Adelson 1966), that women tend to be more attuned to the interpersonal dimensions of life than men, it is even more surprising to find that research on the social aspects of female addiction is virtually nonexistent.

The aim of the present study was to explore various aspects of the support structure for addicted women compared to addicted men and a comparison group of socioeconomically similar women (presumed to be nonaddicted) in an attempt to identify those critical elements that might be usefully attended to in treatment.

There is a small but diverse body of literature on the general topic of supportive social relationships. The obviously relevant concepts to be derived from these writings will be presented first in an effort to provide some framework for the discussion of our own research. Second, findings specifically relevant to women and drug users will be discussed. The third and largest section is devoted to the presentation of our major descriptive results.

While definitions of social ''pport vary in the literature, all seem to share three basic elements:

1. material aid--the provision of physical items such as money, shelter, food, or work.

2. cognitive aid--the provision of mentally held items such as information or counseling.

3. emotional support--the provision of positive affect that conveys the feeling of value such as love, respect, or praise.

While nearly any social relationship may be supportive for one of its members, sources of support tend to fall into the three main groups: family or kin; friends, neighbors, and acquaintances; and professional help givers (including formal support groups such as Alcoholics Anonymous and Weight Watchers) (cf. Pinneau 1975). Source distinctions are important for at least two reasons. First, certain sources may be viewed by the recipient as more valid than others. This is exemplified by drug addicts in treatment who demand ex-addict counselors, believing that direct experience of the problem is a necessary precondition to helping others overcome the problem. Second, certain sources are simply more capable of providing aid in particular areas than others. For example, most people would rather go to a physician when confronted with severe physical distress than a nonphysician neighbor. Likewise money can only be obtained from those who have, or can get, funds.

Researchers tend to disagree on the predominant characteristics and conditions necessary for the transmission of support. Cobb (1976), for instance, conceives of social support simply as classes of information which happen to emanate from other people. Others, notably Gerald Caplan (1974), tend to accentuate the interpersonal aspect--that is, social ties and groupings as support. R. D. Caplan et al. (1974) qualify the operation by asserting that support must move the recipient toward goals which the recipient desires.

The "social support" literature per se comes largely from the psychological and psychiatric traditions. Sociologists and anthropologists, however, have for some time derived similar conceptions through network analysis (e.g., Barnes 1972; Boissewain and Mitchell 1973; Tolsdorf 1976). In fact, much of our knowledge of the importance of human interaction in terms of support is based on these very thorough investigations of systems of social linkages (e.g., Sussman and Burchinal 1962).

All of the various literatures point to the predominance of the family as a source of social support. Since the present research deals specifically with city dwellers, the discussion will focus briefly on urban family study. In a review of the family

interaction and support literature, Nye and Berardo (1973) note that though sociologists previously regarded urban society as relatively devoid of traditional kin support systems, scientists have since "discovered" that urban families do include more than "nuclear" arrangements. While cautioning that most studies have been focused on majority-group, middle-class populations, they present evidence of kinship assistance in the form of financial aid, exchange of services, gifts, and advice among others.

Carol Stack (1974) observed very intense systems of interaction and mutual support among impoverished urban blacks. Living and communicating primarily with the women, Stack was led to conclude that their cooperative domestic exchanges, characterized as "tenacious, active lifelong network(s)," were in fact the essence of survival in urban poverty demanding that all persons demonstrate strong kinship loyalties. Schneider and Smith (1973) noted similar support structures across various lower class ethnic groups. Blacks, southern whites, and Spanish Americans in Chicago emphasized "help, cooperation, and solidarity" with a wide range of kin and created kin (e.g., just like a sister).

An early urban neighborhood network study by Bell and Boat (1957) showed that in high as well as low socioeconomic status areas, kin were most important in terms of informal participation (e.g., getting together, reliance for help). This widespread familialism is carried a bit further by Caplan and Killilea's (1976) idea of the family as a critical source of support during personal crisis. As a psychiatrist, Caplan focuses on the aspect of family support in healthy adjustment and adaptation to crisis.

The drug literature is strangely divided on the role of kin in addiction, dwelling in particular on addict-mother and addict-spouse relationships. While forwarding the credible notion of family therapy as a tool in overcoming drug addiction, Wolk and Diskind (1961) describe the mother of the paroled addict as having a "neurotic, masochistic need to keep (her child) in a state of addiction . . . (and is) most happy when he is ill and completely dependent upon her" (p. 149). Coupled with the addict's emotional debility, the mother-child relationship is characterized as a kind of "diseased reciprocal aid." In Chein et al. (1964), mothers fare only slightly better because of the wider range of mother types encountered. Still, some were shown to be seductive, emasculating, and in general "atypical or unusual" (p. 274).

These studies, like most addiction studies, are centered on male addicts. Few descriptions of mother-daughter relationships exist. Chein et al. (1964), basing their judgments on a small (20) group of women admitted to a hospital for addiction treatment over 20 years ago (1955, 1956), describe mothers of addicted women as--

> insecure women, concealing their conflicts and insecurities behind a facade of efficiency, responsibility, and excessive mothering; they were usually religious and prone to preaching; they were opinionated, judgmental,

> rigid, authoritarian, and dictatorial; and they were punitive or indifferent in regard to their daughter's sexual functions and development. (p. 313)

Ties with parents were described as "weak."

As is evident by the reference dates, the addict-mother relationship work is very dated. This characteristic alone suggests or accounts for several problems. First, these early explorations were more subject to the societal biases of the period. Gender and cultural stereotypes were pervasive. Second, the methods were heavily based on subjective perceptions (e.g., clinical judgments), with few of the standard experimental controls used presently. Third, addicts over 15 years ago may have been very different from the individuals who become addicted to drugs today.

In apparent contrast, Wallace's (1976) network analysis of Detroit heroin addicts evidenced enduring ties with mothers among both women and men addicts. Women, in fact, stated that they would miss their mothers more than anyone else if they were no longer around.

Relationships with spouses or partners have been subjected to a little more research which has produced more cohesive results. In general, addicted women are more likely than addicted men to be married to or involved with other addicts (O'Donnell et al. 1967; Wallace 1976). Interestingly, the "sick wife" theory (that the wife exhibits a kind of pathology that supports the drug-abusing behavior of the husband) used to describe wives of male addicts (Taylor et al. 1966; Wolk and Diskind 1961) has not been developed to describe husbands of addicted women. There is some evidence to suggest, though, that addiction is more likely to be transferred from husband to wife than vice versa (O'Donnell et al. 1967).

Recent evidence suggests that addicted women tend not to follow traditional marriage rates with reports of from 48 percent to 78 percent of women in treatment as unmarried (Benward and Densen-Gerber 1975; Eldred and Washington 1976; Raynes et al. 1974; Suffet and Brotman 1976). Actual rates reflect age and some racial differences. Addicted women likewise are reported to have separation and divorce rates ranging as high as 24 percent to 50 percent (Chambers et al. 1970; Ellinwood et al. 1966; Weiland and Chambers 1970), though some racial differences may exist.

Given spouse or partner presence, the literature suggests that those relationships are supportive. Wallace (1976) found that female and male addicts deemed spouses and lovers as their most important supportive relationships. The women seemed to depend on the men for all types of support and depended on them for companionship. In a therapeutic context, Farkas (1976) reports that couples who evidenced a high degree of "homeostasis" by entering and remaining active in treatment together had potential for a more positive treatment outcome than couples who were not dually active.

Other significant sources of social support addressed in the literature are peers and formal self-help groups. Peers have been designated as initiators of addict drug use (Brown et al. 1971; Chein et al. 1964), as well as initiators of cessation attempts (Schasre 1966). Caplan and Killilea (1976) emphasize the importance of mutual help organizations such as Synanon in the stemming of the crisis of addiction.

In light of the above findings, the following specific aspects of supportive social relationships were addressed in the present study:

1. Perceived adequacy of respondents' friendships in general

2. Nature and amount of support received from relatives

3. Degree of closeness to, nature and amount of support received from spouse or lover

4. Degree of closeness to, nature and amount of support received from best same-sexed friend

5. Coping style--given specific problems, who respondents tend to go to for support and the extent to which nonsocial outlets are used

6. The extent to which the respondent has to contend with adversary relationships. (We felt that such negative influences, when perceived as such, could be just as important as supportive relationships.)

Though several very cogent theoretical perspectives are evident in the social support and network literature, it seems a little premature to attach a set of preconceived notions derived largely from research populations quite dissimilar from both our addict and comparison groups to our present investigation. This is essentially a structural exploration in which we hope to discover theoretical frameworks inherent to these particular groups.

METHOD

The methodology including information on sample selection and the demographic characteristics of the groups is presented in the introduction, and the reader is encouraged to refer to it. Only brief descriptions of these particulars appear here. Questionnaires were administered to--

1. Women in treatment for heroin addiction in mixed-sex treatment centers in Detroit, Los Angeles, and Miami (n=146; Detroit only n=73);

2. Men in treatment for heroin addiction in mixed-sex treatment centers in Detroit, Los Angeles, and Miami (n=202); and

3. Women from the same Detroit neighborhoods in which many of the treatment centers were located, representing a presumably nonaddicted, socioeconomically similar comparison group for the female addicts (n=175).

Comparison women were not asked questions dealing with drug treatment and addicted men were not asked all of the mother-relationship items.

For the most part questions were composed by the research staff specifically for the present study. A few of the general friendship items, however, were obtained from the 1976 national replication of the 1957 study[1] "Americans View Their Mental Health."

RESULTS AND DISCUSSION

General Friendship Patterns

These questions were designed as non-person-specific indicators of the respondent's general friendship patterns.

Addicted women in Detroit were found to be significantly more likely than comparison women to report having "no friends" in their neighborhood, and women in treatment overwhelmingly complained of being lonely some or most of the time. Actual percentages are presented in tables II-1 and II-2. On all other items the women did not differ.

When all female and male addicts were compared, virtually the same distinctions held. Women as opposed to men tended to have "no friends" in their neighborhoods and were significantly lonelier. In an interesting reversal, male addicts, rather than having enough friends, wanted more [X^2 (1)=13.43, $p < 0.01$]. Importantly

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[1] J. Veroff, E. Douvan, and R. Kulka, personal communication, September 12, 1975.

[2] The reader is reminded of three points made in the introduction:

1. The comparison women are contrasted only with addicted females in Detroit, while basic male versus female in treatment comparisons include all interviewed respondents in treatment from all three cities.

2. Only the modal urban female client is emphasized, with presentation of results undifferentiated in terms of race, geography, social class, and type of treatment program.

3. Data presentation at this stage is descriptive.

TABLE II-1.—Friends in neighborhood--response distributions

Groups	n	Responses (in percent) None	Few	Many	Nearly everyone
Detroit addicted women	73	34.2	50.7	9.6	5.5
Detroit comparison women[1]	175	15.4	49.7	19.4	15.4
All addicted women	146	32.9	52.1	9.6	5.5
All addicted men[2]	202	14.9	67.3	9.6	7.9

[1] χ^2 (3)=15.81, $p < 0.01$.

[2] χ^2 (3)=16.27, $p < 0.01$.

over 90 percent of the respondents in every group declared that they had at least a few good friends.

The general pattern indicated in table II-2 is that addicted women, more so than either addicted men or similar comparison women, feel lonelier and seem to be more isolated. Since these women admit to being lonely, it is unlikely that they are rejecting potential friendships. It would appear that others are simply less likely to befriend them. Maglin (1974) believes that women addicts become pariahs in their own communities and often are considered "bad company" by their nonaddicted friends.

TABLE II-2.—Feelings of loneliness--response distributions

Groups	n	Responses (in percent) Most of time	Some of time	Hardly ever	Never
Detroit addicted women	73	24.7	61.6	9.6	4.1
Detroit comparison women[1]	175	12.6	42.3	30.9	14.3
All addicted women	146	28.8	52.1	13.7	5.5
All addicted men[2]	202	16.8	52.0	26.2	5.0

[1] χ^2 (3)=22.89, $p < 0.01$.

[2] χ^2 (3)=11.93, $p < 0.01$.

These questions address mother-respondent relationships specifically by ascertaining the presence and location of and perceived support from mother figures. Males were not asked these questions. As presented in the later section on coping styles, however, all respondents had the option of mentioning mother as well as any other individual or institution as supportive figures in the resolution of difficulties.

The results indicate, as shown in table II-3, that addicted women were somewhat more likely to have a mother alive and living nearby--either with her, or in the same neighborhood or town--than the comparison women. Women in both groups, though, reported in substantial proportions that their mothers were either "lots of help . . . always there when needed" or "some help . . . could count on her in an emergency" (table II-4).

This is a very encouraging finding and contrasts sharply with the admittedly dated Chein et al. (1964) characterization of ties between female addicts and mothers as weak. The results support Wallace's (1976) observation of addicted men and women in Detroit. Nearly all of her respondents reported continuing maternal contacts and emotional attachments.

Since help received from mothers may be relatively more important to addicted women (because of greater needs), and certainly a more stable and dependable means of support than most, addicted women may be choosing to live near their mothers. While selection of living site is certainly related to a variety of factors (which may include for addicts drug availability, contact, familiarity with area), stability and dependability of help source may be a final determinant.

TABLE II-3.—Mother's place of residence--response distributions (in percent)

Responses	Detroit addicted women (n=72)	Detroit comparison women (n=175)
With respondent	25.0	28.6
Same neighborhood	19.4	9.1
Same town	34.7	21.1
Other place	15.3	27.4
Not alive	5.6	13.7

χ^2 (4)=14.59, $p < 0.01$.

TABLE II-4.—Perceived help from mother--response distributions (in percent)

Responses	Detroit addicted women (n=71)	Detroit comparison women (n=160)
Lots	52.1	65.6
Some	33.8	21.3
Little	8.5	6.9
None	4.2	3.1
Causes problems	1.4	3.1

Differences not significant.

Partner-Respondent Relationships

These questions deal specifically with partner/lover/spouse-respondent relationships. Comparison women were not asked the drug-related items. We felt that the critical determinant--in terms of social support--was the presence of a relationship rather than the legal status of that relationship. If respondents reported that they were not presently involved in a "meaningful relationship," they were then asked about the presence of a "husband, boyfriend, or lover." If the latter did exist, questions were centered on the individual. Therefore, the lack of "meaningfulness" in a relationship did not preclude its existence.

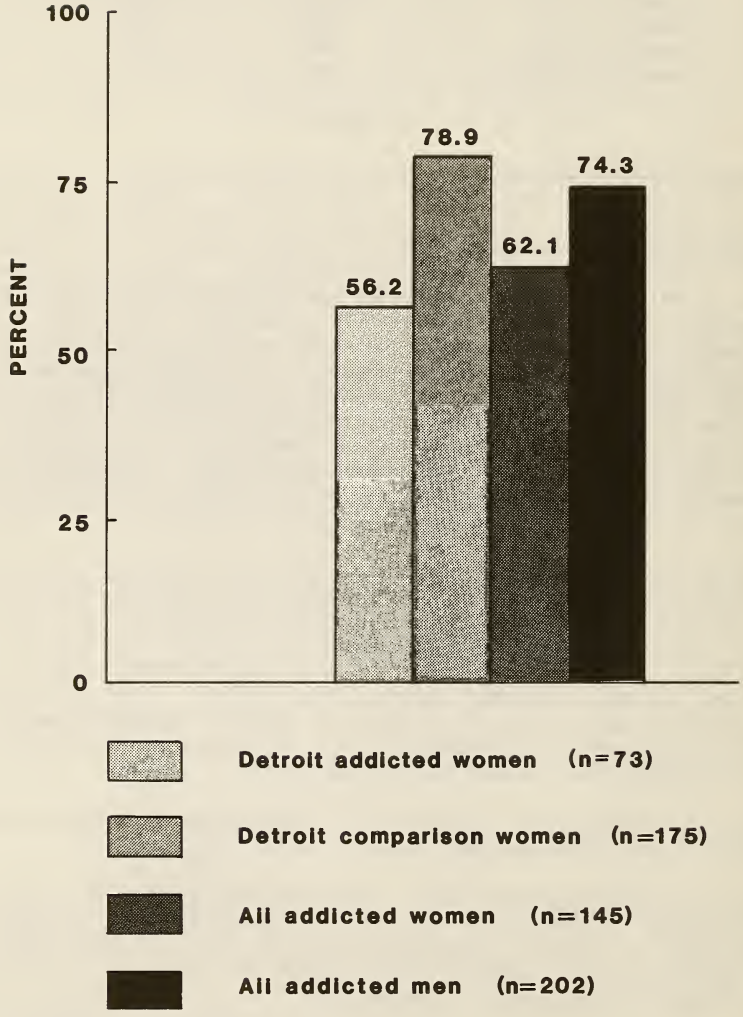
As shown in figure II-1, the basic difference between addicted and comparison women was in the existence of a relationship--only 56.2 percent of women addicts compared to 78.9 percent of control group women reported being involved with someone [X^2 (1)13.21, $p < 0.001$]. Beyond this, however, the most striking feature of the data is the similarity between the groups. That is, once established, the features of lover or spouse relationships are basically the same for addicted and comparison women from similar environments. The women did not differ in--

Length of relationship. Members of both groups had been with their partners approximately 4 years.

Degree of togetherness. The questions addressing this issue were summed to form an index with Cronbach's Alpha reliability coefficients of 0.78 for comparison and 0.75 for addicted women. Both groups scored slightly over 12 out of a possible 15, thus evidencing high degrees of togetherness.

How well the couple gets along. Most of both groups reported that they got along "very well."

FIGURE II-1.—*Proportions of all groups reporting meaningful romantic relationships*



Satisfaction with relationship. Both groups were satisfied with their relationships, scoring slightly over 3 on a 4-point scale (4="very satisfied").

Relative perceptions. Addicted and comparison women did not differ in their perceptions of who "had the most say" and who "loved the other most" in the relationship. Over 40 percent of each group indicated that their partners generally had more say, and nearly half of each said that they loved each other equally.

In terms of differences, significantly more comparison than addicted women reported that they tried harder than their partners in the relationship [χ^2 (2)=10.45, $p < 0.01$], while more addicts than comparisons claimed that they, as opposed to their partners, needed the other most [χ^2 (2)=10.45, $p < 0.01$].

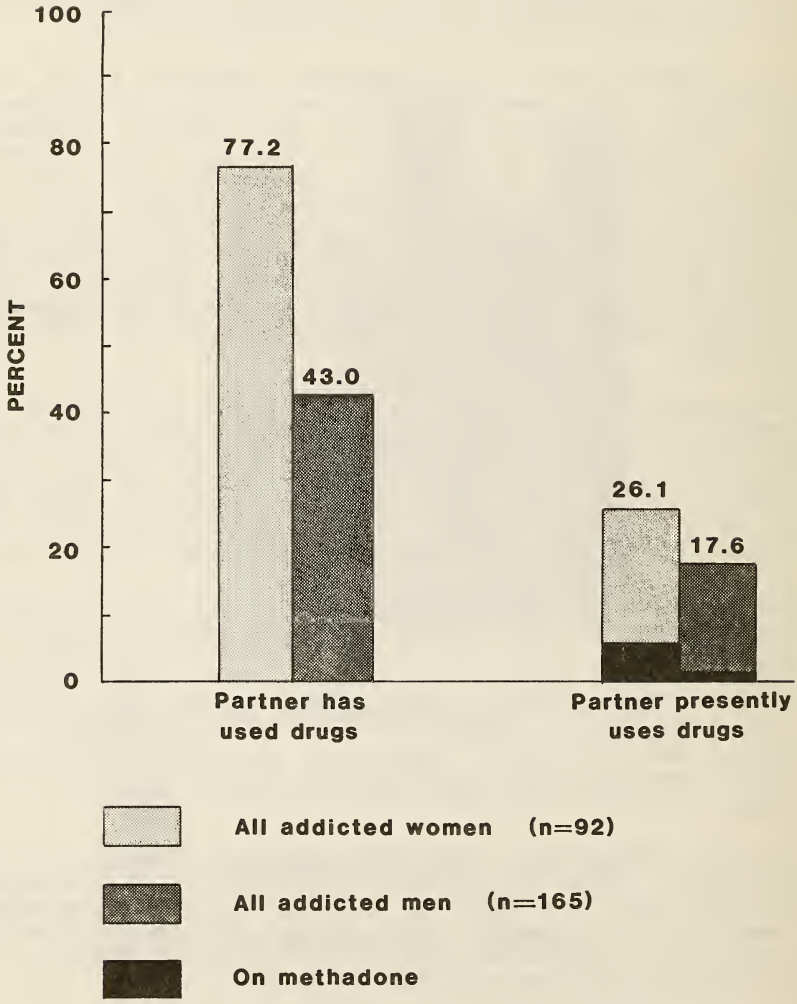
Male versus female addict comparisons evidenced a few more differences, many seemingly indicative of fairly straightforward sex effects (figures II-1 and II-2). With respect to incidence, 62.1 percent of all females and 74.3 percent of males reported being involved in a meaningful relationship [χ^2 (1)=5.88, $p < 0.05$]. Furthermore, as supported by Wallace (1976) and O'Donnell et al. (1967), women more often than men (77.2 percent versus 43 percent) were associated with individuals who had used drugs [χ^2 (1)=27.85, $p < 0.001$]. Women were also more likely to have a partner presently on drugs--particularly methadone--which probably represents paired treatment attempts [χ^2 (3)=8.02, $p < 0.05$].

Men reported having longer relationships--5.2 years versus 3.7 years [t (328)=3.22, $p < 0.01$], due perhaps to the fact that they are older than the women; were more likely to "have the most say" in the relationship [χ^2 (2)=29.98, $p < 0.001$]; and more often reported that their partners tried harder in the relationship [χ^2 (2)=19.03, $p < 0.001$]. In all other aspects, the groups did not differ, with both attributing relational difficulties to drug usage.

The predominant aspect of these data is the absence of "disorder" and "abnormality" as described in the literature. Relationships are fairly long lasting and stable. Problems encountered are similar to those reported by nondrug users in similar environments. Most importantly, women as well as men were overwhelmingly supported in treatment attempts by their partners--73.2 percent and 78 percent, respectively, said that partners were "very happy [for them]--glad that [they were] trying to get off drugs."

The data indicate, then, that relationships for addicted women are not unusual, given our measures. Nevertheless, addicted women are less likely than either the addicted men or the comparison women to be involved in relationships. This finding seems to support the recent marital status literature presented earlier. Do our own marriage rates corroborate this trend?

FIGURE II-2.—*Proportion of addicted respondents with drug-using partners*



As shown in figure II-3, comparison women in Detroit were more likely than their addicted counterparts to be presently married (27.4 percent versus 17.8 percent), and less likely to be separated (10.9 percent versus 23.3 percent). Other categories evidenced similar rates, though, with approximately half of both groups never married. The larger groups of addicted men and women had similar marital status, showing again very large unmarried rates (figure II-4).

Interestingly, as indicated in table II-5, marital status was only minimally related to the existence of a romantic involvement, with a tendency among all groups of women to have a relationship if married and to not have one if separated. However, single, divorced, and widowed women were as likely as not to be involved. Men reporting relationships were more likely to be married and less likely to be single or widowed, but equally as likely to be separated or divorced.

The data, as a whole, indicate that, contrary to other recent literature, addicted women are as likely as anyone else in similar circumstances to marry. Given the separated and divorced rates, however, those marriages appear to be more likely to break down. Though there is little evidence to support any particular rationale, there are possible explanations:

Dependence. Addiction for women may, paradoxically, foster the development of a sense of independence. They are forced to learn to acquire large sums of money, must certainly at some point obtain drugs on their own, and in the process learn to artfully deal with other people to achieve those ends. As shown in chapter 1, the addicted women are as assertive as the comparison group, therefore, capable of acting in their own interests and being demanding when necessary. Available male partners may be threatened by such behavior since the men in this study tend to hold more traditional beliefs about male versus female roles.

Societal bias. A more traditional argument focuses on the existence of a general societal bias against addicted women. They are often viewed as prostitutes and child abusers (contrary to statistics and common sense) and, to use an overworked but relevant cliche, not deemed desirable daughters-in-law by most (cf. Schultz 1975; Soler et al. 1975). Worse, as demonstrated in chapter 1, the respondents in this study shared this negative portrayal. In social psychology, the "self-fulfilling prophecy" (Merton 1948) has been forwarded to explain the consequences of such thoughts. If you believe an event will take place, that belief in and of itself increases the likelihood of the occurrence of that event. The individual is thought to act unconsciously or subconsciously in behalf of the event. In the present situation, women who believe themselves to be bad or undesirable will then be viewed by others as bad or undesirable because their actions will convey those messages.

FIGURE II-3.—*Marital status of Detroit addicted and nonaddicted women*

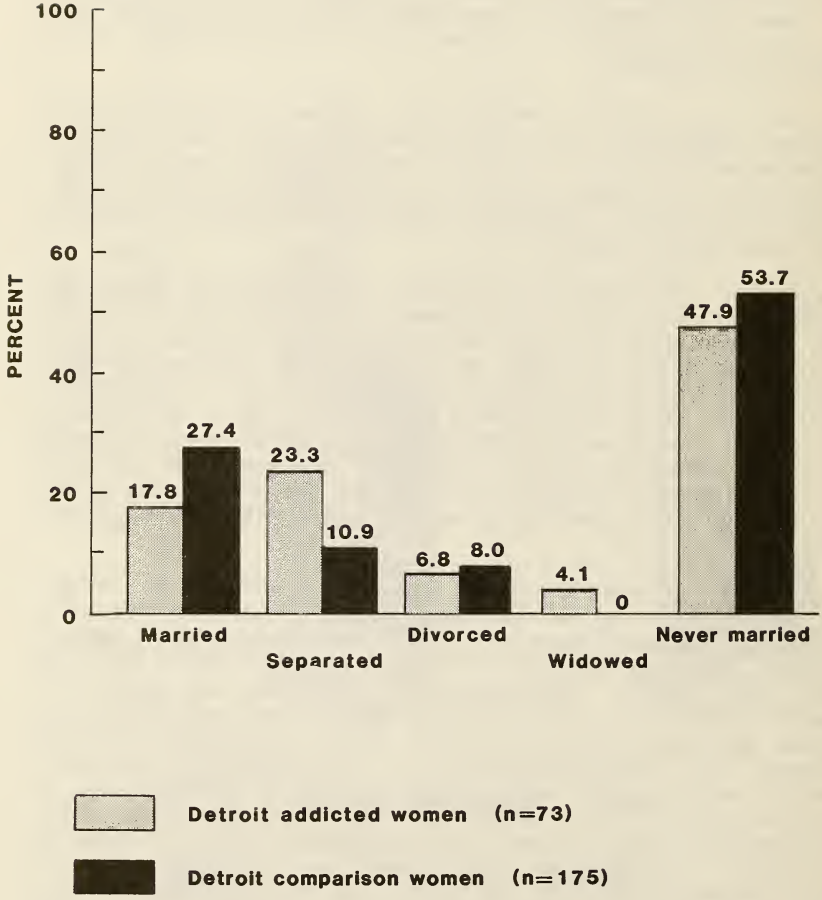


FIGURE II-4.—*Marital status of all addicted women and men*

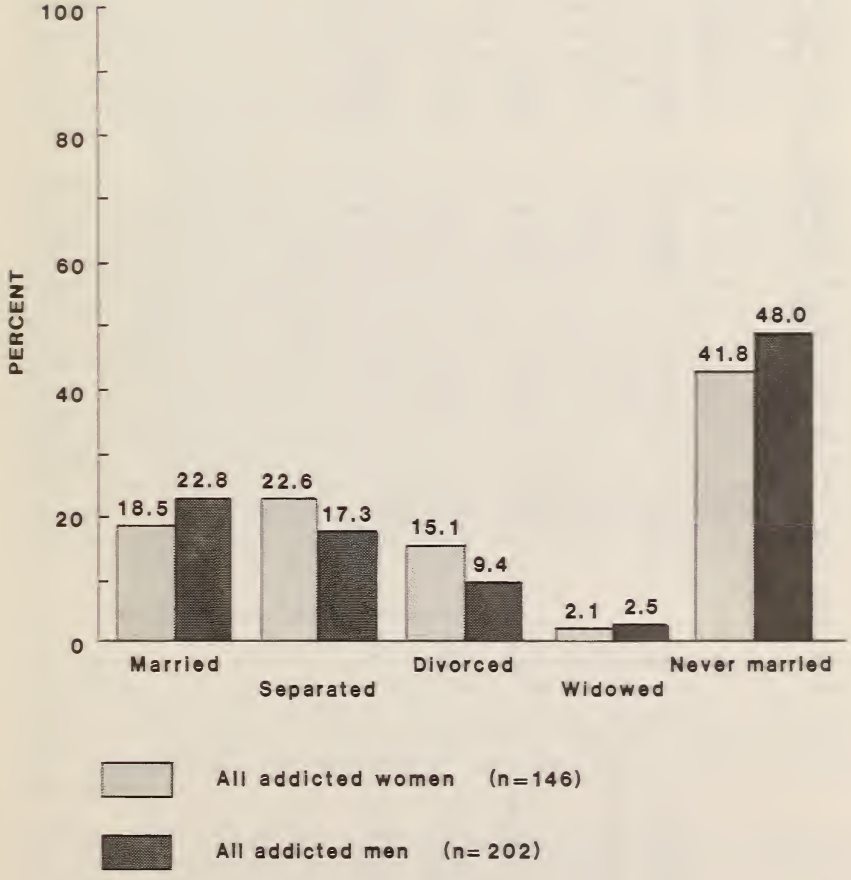


TABLE II-5.—Cross-tabulation of marital status versus existence of meaningful romantic relationship (in percent)

Groups	n	Relationship	Marital status					
			Married	Separated	Divorced	Widowed	Never married	χ^2 (d.f.=4)
Detroit addicted women	73	Yes	24.4	9.8	9.8	2.4	53.7	[1]12.06
		No	9.4	40.6	3.1	6.3	40.6	
Detroit comparison women	175	Yes	32.6	9.4	6.5	0	51.4	[1]10.03
		No	8.1	16.2	13.5	0	62.2	
All addicted women	145	Yes	24.4	12.2	16.7	1.1	45.6	[2]16.83
		No	9.1	38.2	12.7	3.6	36.4	
All addicted men	202	Yes	30.0	17.3	8.7	1.3	42.7	[3]20.25
		No	1.9	17.3	11.5	5.8	63.5	

[1] $p < 0.05$.

[2] $p < 0.01$.

[3] $p < 0.001$.

Victim of societal trends. A third possibility is that these women are simply being forced to bear the brunt of a general societal trend. Nationally, divorce rates doubled between 1965 and 1975 (U.S. Bureau of the Census 1976). When problems exist, couples today seem more likely to part than stick it out for any number of formerly relevant reasons (e.g., children, religion, family). Addictions bring at least an additional set of substance-related problems. This additional "hassle" may be just enough to tip a precariously balanced relationship or marriage. This view is made more plausible by the similar marital status pattern exhibited by male addicts. The absence of a similar relationship incidence pattern may be a function of partner availability--men, being fewer in number and therefore in greater demand, have more options.

The discussion has been heterosexually based because the incidence of same-sex love relationships in this sample is virtually nil. Some, notably Maglin (1974), have estimated that as many as one-third of addicted women are either bisexual or lesbian. In anticipation of some greater incidence of same-sex relationships, our question was phrased without sex reference: "Is there one main person in your life that you share a deep and meaningful relationship with--someone that you might be in love with?", with a direct followup only if sex of partner was unclear.

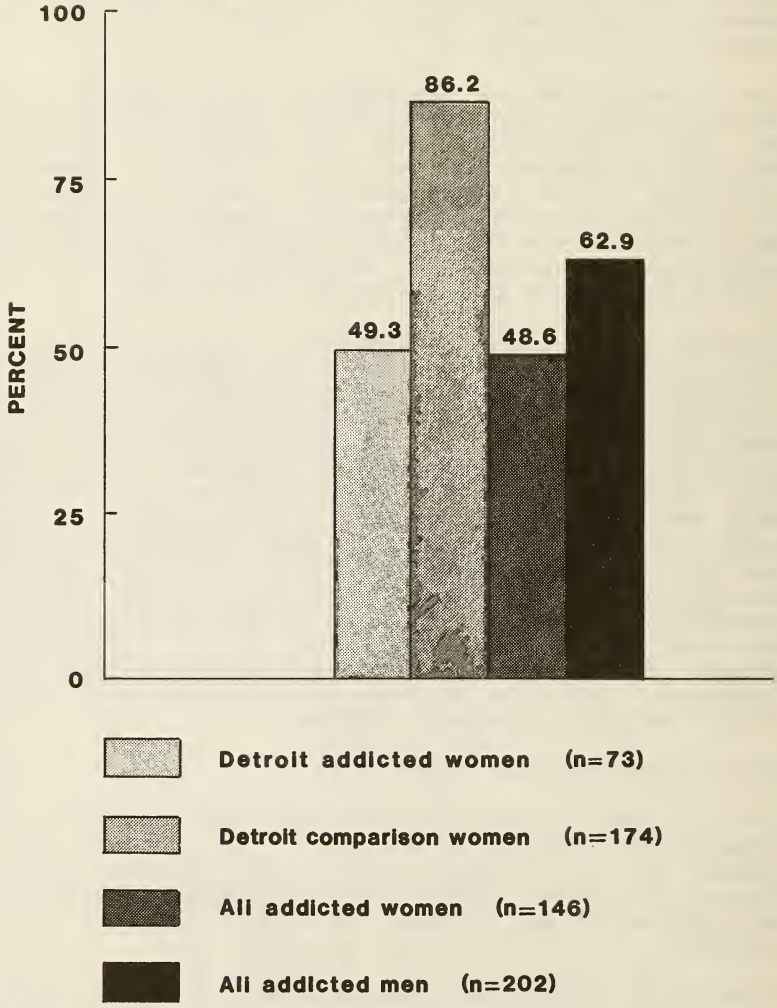
Inasmuch as this question was viewed by research staff as relatively nonthreatening, the results were somewhat unexpected. There are three possible explanations. First, our question may not have worked. Though this is seemingly unlikely because of other extremely personal and sensitive information freely offered by the respondents, traditional drug programs are often particularly antagonistic toward homosexual relationships. Therefore, some women may have been fearful of exposure, despite assurances of confidentiality (Soler et al. 1975). Second, our research may not have tapped centers most likely to attract women with same-sex sexual preferences. This may be true, since this questionnaire could not be given to the women-oriented programs that were more supportive of alternate lifestyles than traditional centers. Third, previous estimates may have been inflated. The "estimators" could be exhibiting bias by lumping all possible forms of subjective "deviancy" together.

Best Friend-Respondent Relationships

Questions were structured to view the relationship between the respondent and her or his best friend of the same sex. At first glance, the most striking aspect is the apparent similarities between the groups. However, the two differences that do exist are fundamental and potentially more important than all other elements.

Figure II-5 shows that Detroit addicted women and addicted women on the whole are less likely to have a best friend than Detroit comparison women and addicted men, respectively [χ^2 (1)= 37.64, $p < 0.001$; χ^2 (1)=7.01, $p < 0.01$]. Furthermore, as shown

FIGURE II-5.—*Proportions of all groups reporting a best same-sex friend*



in table II-6, all addicts tend to give and receive practical help (e.g., financial, housework, child care) from best friends, while comparison women predominantly exchange emotional help (e.g., love, respect, confidence, sharing activities) with best friends.

This finding could be a direct result of the addiction process. That is, the practical needs of addicts are so great that they may overshadow emotional needs and fulfillments. In terms of immediate needs only, practical help is viewed as having greater importance and thus more likely to be elicited by direct questioning. If the responses do reflect a real deprivation in terms of emotional support, addicted women are truly in an unenviable state. We have seen thus far that they are more likely than other samples to have no friends in the neighborhood, to have no current romantic relationships, to be separated from spouses, to have no best same-sex friends, and to receive less emotional support from friends. A picture of isolation is developing; a development all the more disturbing when findings indicate that existing relationships are basically no different from those of other studied group members.

DYSFUNCTIONAL RELATIONSHIPS

As mentioned in the background section, the existence of aversive or dysfunctional relationships can potentially be as disturbing as a lack of supportive relationships. The drug lifestyle may indirectly contribute to the development of such linkages (through unkept commitments, criminal activity, etc.). While all groups were equally likely to know people who disliked or caused them trouble, 43.5 percent of addicted women, as opposed to only 20.6 percent of comparison women in Detroit knew more than one such person [χ^2 (2)=6.11, $p < 0.05$]. Since no such sex differences emerged in the sex comparison, the difference is probably a function of the drug-abuse lifestyle.

While all groups were equally likely to cite an especially troublesome individual, comparison women were nearly twice as likely (31.6 percent) to indicate that "no one" disliked them than addicted women (16.9 percent). In both instances, comparison women were more likely than other groups to mention family members.

The pattern of insufficient support structure for addicted women is then further developed by the dysfunctional relationship results. In addition to having fewer supports in general than the other groups in the study, they also have more potentially stressful linkages than the comparison women.

TABLE II-6.–Types of help exchanged by respondents and best same-sex friend (in percent)[1]

Groups	n	General	Emotional			Practical		
			Love, respect, etc.	Sharing of activities	Other	Financial help	Housework/ children	Other
Detroit addicted women	36	33.3	36.1	19.4	25.0	58.3	41.6	19.4
Detroit comparison women	150	22.0	53.3	52.6	10.0	44.6	34.0	23.3
All addicted women	69	43.4	31.8	24.6	31.8	42.0	27.5	23.1
All addicted men	127	33.0	27.5	34.6	14.9	61.4	2.3	33.8

[1]Percentages do not sum to 100 because more than 1 response was allowed.

COPING MECHANISMS

Through analysis of the respondents' actual responses to the stress invoked by specific life difficulties we can better understand the nature and depth of their support structure. Our exploration took several forms:

1. Given the specific aversive but common emotional conditions of depression and anger, how does the respondent cope

2. To what extent is the respondent confronted by specific practical problems

3. Given actual practical difficulties, who, if anyone, does the respondent go to for help

Coping with emotional stress. As shown in table II-7, there were clear response style differences between the groups. When upset or angry, drug-abusing women were more likely than comparison women to report that they "get away from where [they] are and go off by [themselves]," "just stick it out," and "take drugs." Addicted women, as opposed to men, were more likely to report that they take it out on their children and were more likely to "lose their temper(s) and yell."

When depressed (table II-8), the treatment group in Detroit was more likely than comparison women to indicate that they "just stick it out," take it out on their children, and take drugs. The addict sex breakdown showed that women were more likely to take it out on children and "go to bed," while men were more likely to "talk things over with their wives or girlfriends."

On the whole, though, addicted women seemed more prone to engage in nonsocial, primarily internal sorts of behavior for stress alleviation. At the risk of prematurely suggesting causation, it seems clear that one result of an insufficient support structure is the development of nonsocial coping styles (although the alternative is minimally plausible). For example, does the lack of primary social support contribute to the high incidence of or continuation of drug use for the alleviation of common emotional crises among addicted women? The fact that men and women did not differ on reports of drug use as a coping mechanism, does not necessarily negate this argument. That is, given apparently equal types of use, causal factors may be quite diverse. Since, as Chodorow (1974) has asserted, women seem to be more dependent on external supports than men, the lack of such structures may be potentially more devastating.

Incidence of problems. Figure II-6 shows the percentages of each group reporting the occurrence of the listed problems during the month preceding the interview. The results are fairly astonishing. While addiction clearly relates to an increase in financial, health, and interpersonal problems (as indicated by the higher percentages for all addicts), female addicts are particularly and disturbingly

TABLE II-7. —Reported behavior when upset or angry (in percent)

Responses	Detroit addicted women (n=72-73)	Detroit comparison women (n=172-175)	χ^2 (d.f.=1)	All addicted women (n=145-146)	All addicted men (n=200-202)	χ^2 (d.f.=1)
Lose temper and yell	60.3	50.9	N.S.	61.6	49.9	[2]5.45
Talk over things (female)	58.9	64.0	N.S.	54.1	53.5	N.S.
Talk over things (male)	42.5	33.3	N.S.	43.8	35.6	N.S.
Get away	87.5	69.9	[3]8.38	81.4	76.1	N.S.
Talk over things (partner)	67.1	65.7	N.S.	67.8	76.2	N.S.
Talk over things (friend)	60.3	65.9	N.S.	56.2	56.2	N.S.
Just stick it out	80.8	54.1	[4]15.57	71.9	68.5	N.S.
Take out on children[1]	21.3	14.0	N.S.	22.9	4.6	[4]21.70
Drink alcohol	17.8	16.6	N.S.	26.0	34.7	N.S.
Take drugs	67.1	9.1	[4]89.54	76.7	79.6	N.S.
Other	19.4	38.9	N.S.	26.9	32.2	N.S.

[1]Includes only respondents with children.

[2]$p < 0.05$.

[3]$p < 0.01$.

[4]$p < 0.001$.

TABLE II-8.—Reported behavior when depressed (in percent)

Responses	Detroit addicted women (n=72-73)	Detroit comparison women (n=172-175)	χ^2 (d.f.=1)	All addicted women (n=145-146)	All addicted men (n=201-202)	χ^2 (d.f.=1)
Go to bed	39.7	36.0	N.S.	45.2	27.7	[3]11.38
Talk over things (female)	54.8	56.0	N.S.	47.6	56.4	N.S.
Talk over things (male)	38.4	32.9	N.S.	38.4	35.8	N.S.
Get away	89.0	73.6	[2]7.21	85.6	78.7	N.S.
Talk over things (partner)	58.9	62.3	N.S.	61.6	74.8	[2]6.84
Talk over things (friend)	58.9	62.6	N.S.	52.1	53.7	N.S.
Just stick it out	79.5	62.1	[2]7.05	73.8	72.1	N.S.
Take out on children[1]	19.7	11.5	N.S.	21.0	6.4	[3]15.11
Drink alcohol	20.5	14.9	N.S.	28.8	32.2	N.S.
Take drugs	75.3	8.0	[3]116.33	82.2	83.7	N.S.
Other	16.7	33.7	N.S.	26.2	19.8	N.S.

[1]Includes only respondents with children.

[2]$p < 0.01$.

[3]$p < 0.001$.

FIGURE II-6. *Proportions of all groups reporting problem types*

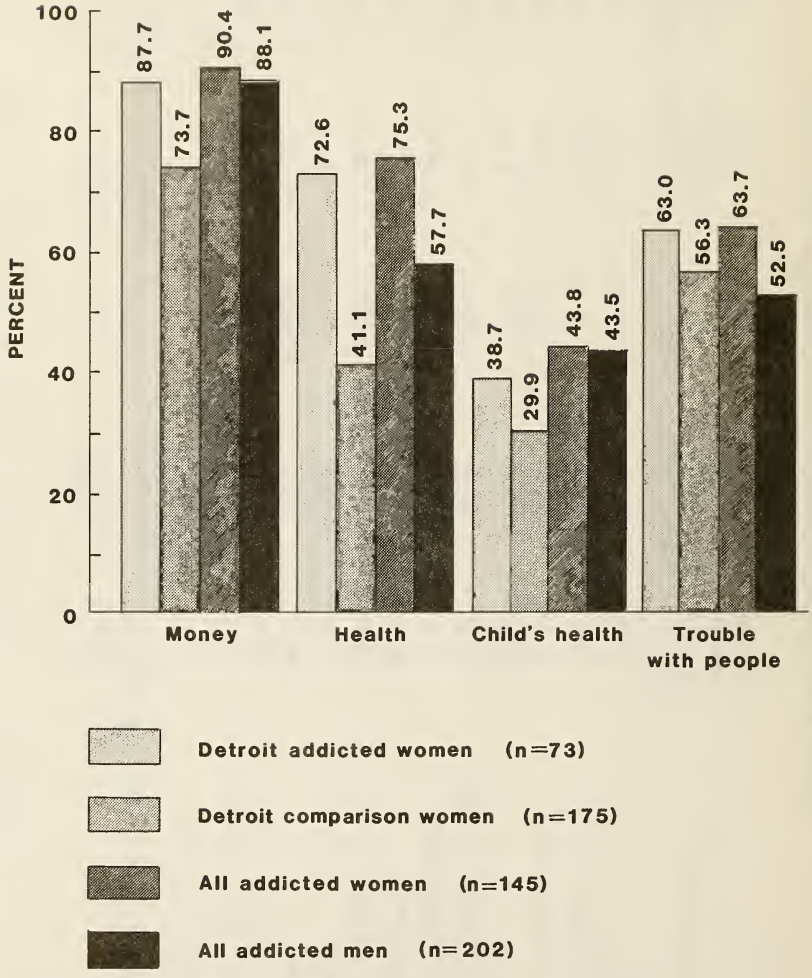
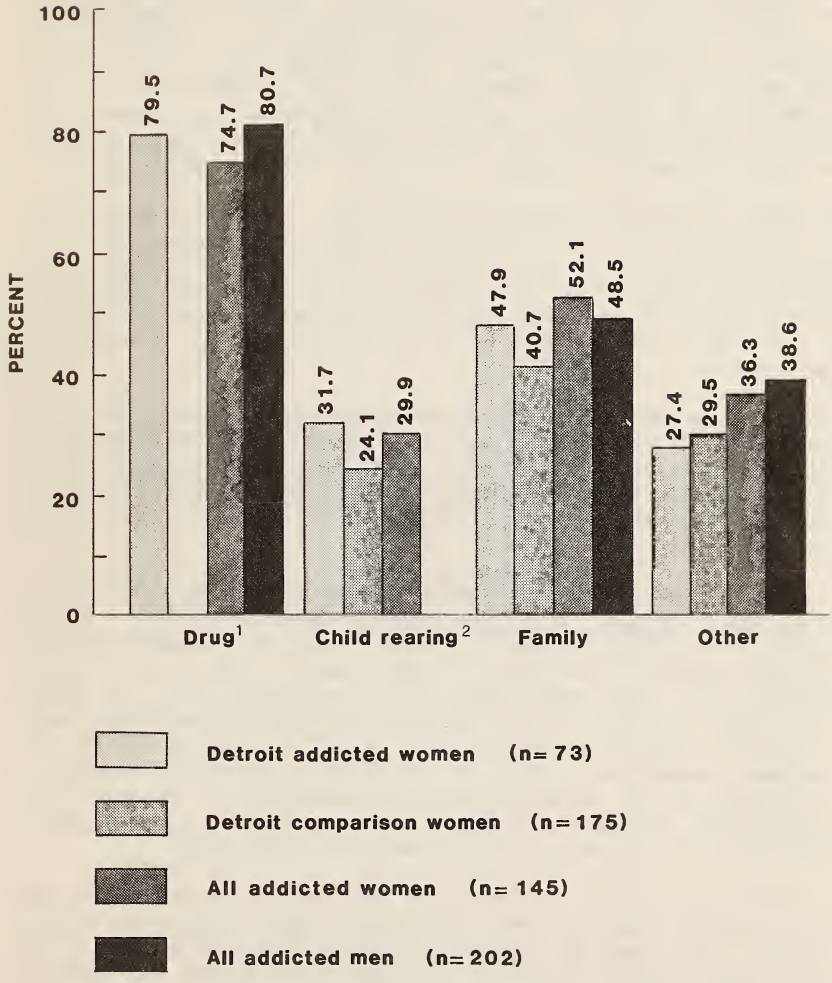


FIGURE II-6.—*Proportions of all groups reporting problem types (Continued)*



[1] Comparison women were not asked. [2] Addicted men were not asked.

prone to health problems. While this has been generally asserted by those particularly concerned with addiction among women, and while serving as a fundamental issue among those involved in the establishment of specialized treatment centers for women, empirical support has only recently been presented (Andersen 1977). That is, recognizing an increased need for medical services among these women, some decided that separate specialized facilities were perhaps the only vehicles that could immediately address that need.

When problem occurrences were summed (dropping drug- and child-related items to form a comparable index), addicted women in Detroit and as a whole had significantly more problems than comparison women and addicted men [t (246)=3.13, $p < 0.01$; t (346)=2.46, $p < 0.05$]. Though the addict sex difference is due primarily to the overwhelming health problems of the women, the reality is that this group is being subjected to significantly more potentially stressful situations than either of the other groups.

Responses to specific practical difficulties. Tables II-9 through II-15 present each of the specific problems incurred by the respondents, and the proportions of those acknowledging the problems who went to each of the listed sources for aid. Respondents mentioned all contacts, hence the percentages do not sum to 100 percent. Several clearly defined patterns are evident in these results:

1. Sources of aid tend to differ radically by problem type. As noted in the background section, general theoretical conceptions of social support have emphasized the importance of source distinctions. Clearly, certain people are perceived among our samples to be more able to effectively deal with certain crises than others.

2. Certain problems elicit common solutions. This, thankfully, was most evident with the health-related problems. When faced with either personal or child illness, most members of all groups solicited professional help. Importantly, addicts as a whole were next most likely to seek medical help at their treatment centers. This could also be an indication that their illnesses are predominantly drug specific, making traditional medical routes less desirable. Whatever the reason, though, treatment centers offering medical services will be utilized and, given the substantial tendency among addicts to use such services, all treatment centers should provide them.

3. Addicts as a group were likely to seek help from similar sources that often differed from sources approached by comparison women. For example, addicts are more likely to seek no help for interpersonal problems (trouble with people and family problems) while comparison women sought help from friends and family. Similarly, addicts sought financial help from friends (though men were slightly more likely to approach their mothers), while comparison women very predominantly went to partners and mothers. These sorts of differences may

TABLE II-9.—Persons respondents sought help from when having financial problems (in percent)[1]

Individual contacted	Detroit addicted women (n=64)	Detroit comparison women (n=129)	All addicted women (n=132)	All addicted men (n=178)
Partner	29.7	44.2	31.8	29.8
Mother	29.7	43.4	30.3	39.9
Father	17.2	14.7	20.5	13.5
Other relative	29.7	21.7	22.7	24.7
Friend	37.5	25.6	34.1	34.8
Neighbor	2.3	6.7	3.1	3.9
Professional	3.1	3.9	6.1	5.6
Clergy	0	.8	3.8	.6
Treatment center	4.7	--	7.6	6.2
Other	4.7	3.9	9.1	5.1
No one	6.3	3.9	6.1	9.6

[1]Columns sum to over 100 percent because respondents could name more than 1 contact.

TABLE II-10. —Persons respondents sought help from when having health problems (in percent)[1]

Individual contacted	Detroit addicted women (n=53)	Detroit comparison women (n=72)	All addicted women (n=110)	All addicted men (n=116)
Partner	5.7	9.7	6.4	6.9
Mother	3.8	15.3	9.1	10.3
Father	0	1.4	1.8	5.2
Other relative	0	9.7	1.8	3.4
Friend	3.8	12.5	3.6	2.6
Neighbor	0	1.4	0	0
Professional	62.3	63.9	64.5	56.9
Clergy	0	1.4	0	1.7
Treatment center	24.5	--	30.9	34.5
Other	0	2.8	1.8	0
No one	26.4	11.1	17.3	13.8

[1]Columns sum to over 100 percent because respondents could name more than 1 contact.

TABLE II-11.—Persons respondents sought help from when having problems concerning their child's health (in percent)[1]

Individual contacted	Detroit addicted women (n=24)	Detroit comparison women (n=26)	All addicted women (n=46)	All addicted men (n=47)
Partner	4.2	7.7	8.9	23.4
Mother	25.0	3.8	22.2	17.0
Father	4.2	0	4.4	8.5
Other relative	8.3	15.4	13.3	6.4
Friend	4.2	3.8	2.2	2.1
Neighbor	0	0	0	0
Professional	54.2	57.7	60.0	29.8
Clergy	4.2	3.8	2.2	2.1
Treatment center	8.3	--	8.9	4.3
Other	0	3.8	0	0
No one	16.7	19.2	20.0	27.7

[1]Columns sum to over 100 percent because respondents could name more than 1 contact.

TABLE II-12.—Persons respondents sought help from when having trouble with a certain person (in percent)[1]

Individual contacted	Detroit addicted women (n=46)	Detroit comparison women (n=98)	All addicted women (n=93)	All addicted men (n=106)
Partner	28.3	17.3	18.3	20.8
Mother	6.5	7.1	8.6	10.4
Father	4.3	3.1	5.4	6.6
Other relative	10.9	15.3	10.8	3.8
Friend	19.6	33.7	16.1	24.5
Neighbor	2.2	4.1	1.1	.9
Professional	6.5	6.1	10.8	6.6
Clergy	2.2	3.1	1.1	1.9
Treatment center	15.2	--	20.4	15.1
Other	2.2	6.1	4.3	3.8
No one	30.4	30.6	30.1	36.8

[1]Columns sum to over 100 percent because respondents could name more than 1 contact.

TABLE II-13.—Persons respondents sought help from when worried about their drug problems (in percent)[1]

Individual contacted	All addicted women (n=109)	All addicted men (n=163)
Partner	15.6	11.7
Mother	19.3	11.0
Father	9.2	6.7
Other relative	11.0	2.5
Friend	14.7	13.5
Neighbor	0	0
Professional	14.7	19.0
Clergy	2.8	1.8
Treatment center	83.5	75.5
Other	0	0
No one	6.4	5.5

[1]Columns sum to over 100 percent because respondents could name more than 1 contact.

TABLE II-14.—Persons respondents sought help from when having child-rearing problems (in percent)[1]

Individual contacted	Detroit addicted women (n=20)	Detroit comparison women (n=21)
Partner	25.0	42.9
Mother	40.0	9.5
Father	20.0	4.8
Other relative	20.0	19.0
Friend	5.0	19.0
Neighbor	0	0
Professional	15.0	9.5
Clergy	0	0
Treatment center	5.0	--
Other	0	0
No one	20.0	19.0

[1]Columns sum to over 100 percent because respondents could name more than 1 contact.

TABLE II-15.—Persons respondents sought help from when having family problems (in percent)[1]

Individual contacted	Detroit addicted women (n=35)	Detroit comparison women (n=68)	All addicted women (n=76)	All addicted men (n=98)
Partner	22.9	26.5	18.4	25.5
Mother	14.3	19.1	14.5	20.4
Father	14.3	5.9	11.8	12.2
Other relative	11.4	26.5	7.9	9.2
Friend	17.1	29.4	14.5	20.4
Neighbor	0	2.9	0	0
Professional	5.7	4.4	5.3	9.2
Clergy	2.9	4.4	3.9	2.0
Treatment center	22.9	--	26.3	16.3
Other	0	0	1.3	1.0
No one	28.6	20.6	27.6	34.7

[1]Columns sum to over 100 percent because respondents could name more than 1 contact.

result from the relative isolation of addicts--particularly women addicts. They tend to have fewer people to go to and may have exhausted the resources they once had because of increased addiction-related demands.

For all problems, addicted women are no more likely to resist seeking help than other groups. That is, even though their basic support structures are more limited, they continue to reach out, seeking alternate resources. For example, while comparison women depend on partners for help in the alleviation of child-rearing problems, addicted women (less likely to have partners) approached their mothers, primarily, but also their fathers for help.

Respondents with children form a special subgroup of the sample. Analysis of the patterns of child rearing should give us a better understanding of their support structures. One basic indicator of child-rearing support is simply the act of keeping an individual's child for her or him. Table II-16 shows where the children of all respondents were living prior to admission to treatment. It is clear that the overwhelming majority of all women care for their

TABLE II-16.—Living arrangements of respondents' children (in percent)[1]

Responses	Detroit addicted women (n=60)	Detroit comparison women (n=85)	All addicted women (n=102)	All addicted men (n=101)
With respondent[2]	68.3	98.8	58.8	40.6
With other parent	5.0	3.5	12.7	63.4
With mother	16.7	2.4	20.6	8.9
With other relative	20.0	0	19.6	7.9
With friend	1.7	0	1.0	0
With foster/institution	6.7	0	11.8	2.0

[1]Columns sum to over 100 percent because respondents answered for each child.

[2]Percent of respondents indicating that at least 1 child fell into category.

own children. Addicts, however, do exhibit a greater tendency to have their own mothers or other relatives caring for their children. Men, as expected, are most likely to have children in the care of the children's mothers.

In addition to the demographic variable of offspring living arrangements, respondents were also asked for their own perceptions of support--whether the respondent had someone who made children easier or more difficult to raise (nonsupport), who cared for the children in emergency situations, and who was most trusted to care for them. The child-care questions were only asked of female respondents, so the results presented are those for comparison versus addicted women in Detroit.

Basically very few differences emerged. Over 90 percent of each group of women had someone who made raising their children easier, usually relatives. The women were also equally likely to not have someone who made raising children more difficult (65 percent for each). In cases where there was a source of disturbance, it was likely, for all women, to be a relative other than own mother. About 75 percent of each group indicated that they received as much help as they needed with the children, and 98 percent of each had someone whom they trusted to take care of the children. The distributional similarities between the women are startling and seem to indicate that addiction, in and of itself, has very little impact on perceived available child-care supports.

Interesting differences are apparent in emergency situations. When ill, addicted women were most likely to call on their mothers (60 percent) and other relatives (56.7 percent) for child-care relief while comparison women depended predominantly on partners (55.3 percent) and secondarily on mothers (44.7 percent) and other relatives (48.2 percent). When forced to leave children "suddenly," addicted women depended primarily on their mothers (51.7 percent), while comparison women were nearly equally likely to depend on mothers (35.3 percent) and partners (28.2 percent). Again, these results are probably due largely to the relative lack of available partners (and thus their aid) for addicted women, and the fact that the physically closest person (usually a partner) is apt to be called upon in emergencies.

Another somewhat general indicator of both coping style and support structure is the extent to which an individual has someone to meet her or his general, but basic, socioemotional needs. As indicated in table II-17, nearly everyone had someone who respected them, but fewer in all groups had someone they spent most of their time with and someone they liked talking with most. Importantly, addicted women seemed no less likely than either of the other groups to have someone to fulfill these needs. That is, they were as able as addicted men and comparison women to name an individual ("no one" responses were relatively few across groups) who fulfilled a number of their socioemotional needs.

Some significant source differences were evident in the "time" and "talk with" variables. Addicted women in Detroit reported that they spent most of their time primarily with family (other than mother) and secondarily with partner. While the pattern is reversed among comparison women, addicted women as a whole spent approximately equal amounts of time with family and partners, but their male counterparts overwhelmingly mentioned wives or girlfriends (in apparent contradiction to the literature portraying very peer-oriented male addicts).

Interestingly, addicted women in Detroit liked talking with partners and family (other than mother) most, while comparison women preferred partners and friends. Few of any group mentioned "no one."

The most important aspect of these data is that drug-abusing groups as well as the comparison group overwhelmingly depend on family and partners for their primary socioemotional needs. Addicted women are not outcasts from the family as popularly conceived. This finding relates to our previous finding of female addict isolation in an important way. That is, the fact that they derive some primary supports from family (as also evidenced in the child-care section) serves to counteract the possibly negative consequences of fewer partners, fewer best friends, and fewer neighborhood friends.

TABLE II-17. —Sources of socioemotional supports (in percent)

	No one	Partner	Mother	Family	Friends	Others	χ^2 (d.f.=5)
			Who treats you with the most respect?				
Detroit addicted women (n=73)	1.4	32.9	15.1	20.5	20.5	9.6	
Detroit comparison women (n=171-172)	1.8	39.8	15.2	14.6	23.4	5.3	3.43
All addicted women (n=144-145)	2.1	33.3	13.2	24.3	17.4	9.7	
All addicted men (n=200-202)	1.0	30.6	25.0	19.9	18.9	4.6	10.69
			Whom do you spend most of your time with?				
Detroit addicted women	8.2	31.5	2.7	42.5	12.3	2.7	
Detroit comparison women	5.2	46.5	3.5	24.4	19.2	1.2	[1]11.37
All addicted women	9.7	35.9	3.4	33.8	13.8	3.4	
All addicted men	13.5	53.0	4.0	5.0	21.0	3.5	[2]49.69

[1] $p < 0.05$.

[2] $p < 0.01$.

TABLE II-17.—Sources of socioemotional supports (in percent)—Continued

	No one	Partner	Mother	Family	Friends	Others	χ^2 (d.f.=5)
				Whom do you like talking with most?			
Detroit addicted women	2.8	35.2	7.0	29.6	18.3	7.0	
Detroit comparison women	.6	32.0	9.3	16.3	39.0	2.9	[2]15.49
All addicted women	2.1	31.5	7.7	24.5	18.2	16.1	
All addicted men	2.5	38.8	13.4	17.9	21.9	5.5	[2]15.63

[2] $p < 0.01$.

CONCLUSIONS AND IMPLICATIONS

This report represents an initial exploration of the basic social support patterns evident in a select sample of addicted women. A rather straightforward modal pattern has emerged. Addicted women were less likely to have friends in their neighborhoods, were more likely to be separated from spouses, and more often reported feelings of loneliness than both presumably nonaddicted women from comparable environments and addicted men. The addicted women, then, seem to be (or at least feel) relatively more isolated with certain critical potential supportive relationships less available to them. This tendency toward isolation, though, does not mean that the women should be characterized as isolates. Nearly all have friends, about half have meaningful romatic involvements, and half have same-sex best friends. As emphasized above, the interpretation is a relative one and subject to at least two alternatives. That is, some have suggested that addicted women may have greater expectations for social relationships and that their perceptions of existing linkages are, then, comparatively diminished. Also, the relative absence of close associates may be indicative of an inability to form or maintain relationships. Whatever the interpretation, it remains clear that the social support systems of addicted women are in general viewed as unsatisfactory by the women concerned (as well as compared to others) and, on that basis alone, warrant attention.

When potentially supportive relationships exist, they are largely similar (based on the aspects measured in this study) to those of the two comparison groups with two notable exceptions: (a) addicted women are more likely than comparison women but as likely as addicted men to exchange practical rather than emotional support with best friends. (b) The addicted women are particularly dependent on their mothers for child-rearing support and, to a lesser extent, financial aid.

Coping strategies of addicted women were not strikingly different from those of others. The women had faced significantly more problems in the month preceding the interview than either of the other groups and had more potentially stressful social linkages (e.g., people who disliked them or caused them trouble) than nonaddicted women from similar environments. They were as likely as anyone else, though, to seek help for problems, and mothers reported as many supports for child care as the comparison women. In terms of emotional stress (i.e., anger, depression), however, addicted women, unlike other groups, tended to use nonsocial/internal coping mechanisms. Finally, addicted women, like the comparison group members, are primarily dependent on family and partners for social-emotional needs (i.e., respect, persons to talk to and spend time with).

The remaining discussion will focus on the implications of the present study in two general areas.

Implications for Future Analyses

The data make it clear that many more complex analyses are needed in order to better understand the dynamics under study. First, it will be both important and exciting to examine the relationship between the social support measures and the other major areas addressed in this study--attitudinal and personality variables, family of origin and social history, and the demographic and drug-use variables. As the reader can readily see, some questions are practically "begging" to be answered. For example, the social background of relative "isolates" versus "nonisolates" should be explored for similar early patterns (realizing that the groups may have biased response styles). If no clear relationship is found among isolates, that would tend to suggest that their present states could be a consequence of addiction. Similarly, we need to know how women with widely variant support systems differ on orientation measures, such as depression, anxiety, assertiveness, and self-esteem. That is, are unsupported women also attitudinally negative, or have they developed very strong attitudinal structures that are either resistant to or resist social mechanisms? Additionally, we need to determine whether patterns of drug use among these very different women vary.

These analyses require the development of a good composite index of support versus isolation. We realize, though, that the concept is not unidimensional and that several facets of the social structure of women may be addressed through several measures.

Our sample is not homogeneous with respect to race or geography. In this report, though, we chose to focus on the modal female addict. Future research could be conducted to account for possible subgroup, particularly ethnic, variation whenever feasible.

Implications for Future Research

The present research, of course, does not begin to address all the relevant issues. It is, after all, an exploratory piece dealing with areas largely overlooked in past research. On the basis of this descriptive review of the data and knowledge of the study's inadequacies, several research directions are suggested:

1. Longitudinal analysis. Examine the experiences of socially supported and socially isolated individuals in treatment. Farkas (1976) has preliminary data which suggests that mutually supportive couples exhibit more active behavior in treatment than nonsupportive couples. Extending observations and measurements of the sort presented here with a number of indices of treatment participation and "success" over the normal length of treatment would add immeasurably to a virtually nonexistent pool of useful and perhaps critical information.

2. Comparisons between supportive and nonsupportive treatment environments. Examine experiences of women in supportive versus nonsupportive treatment centers. Some of the

specialized treatment programs for women (e.g., W.O.M.A.N., Detroit, Michigan; Women, Inc., Dorchester, Massachusetts) have attempted to incorporate some of the support structures which seem to be indicated on the basis of our findings. That is, a few have advocacy systems, child-care components, and have encouraged the development of mutually supportive relationships between clients. This is probably the only way to obtain reasonably direct evidence on the feasibility of the treatment structure as either a surrogate support structure or channeler of support for addicted women.

3. Investigating alternatives to individual treatment. This notion is not at all new and has been employed successfully in community mental health settings (Caplan and Killilea 1976). It is more time consuming and presumably more costly, but if the goal cannot be accomplished adequately by faster, cheaper means, there is no viable alternative. When a woman has an adequate support structure, it should be utilized to her advantage. For example, help other family members understand the treatment process and how they might help; get more couples into treatment (since addicted women are likely to be associated with addicted partners) and into mutually supportive roles. When a woman's support structure appears to be inadequate, develop workable intervention techniques and provide reasonable alternatives. For example, when a woman has a financial crisis and no one to turn to, treatment structures should provide options for her (e.g., short-term loan, work exchanges).

Research, then, should be directed toward assessment of these alternative procedures and others, including the use of family therapy, community contacts, and social service agencies in order to develop adequate support mechanisms.

These suggestions are not exhaustive, of course, and are based on early descriptive data and the relative literature. The sample is small and somewhat select. However, as an exploratory investigation, the study is highly informative and future analyses hold great promise.

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CHAPTER III

A Descriptive Comparison of the Families of Origin of Women Heroin Users and Nonusers

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The family, the basic unit of human organization in most societies, perpetuates human and societal existence through socialization and biological reproduction. Because families are so important in the formation of adult attitudes, familial relations are of great interest and are critical in the development of active, productive individuals. William B. Goode (1959) found "emotional maintenance" to be important in modern family dynamics. Seldin (1972) reviewed the family of the addict and found emotional maintenance to be highlighted in the family interaction of urban populations.

The family of origin (the family one is born into) of drug-addicted people is presumed to deviate from normative socialization patterns exhibited by families of nondrug users. There is a substantial body of literature to support the notion that discontinuity, disorganization, and pathology exist disproportionately in the families of origin of drug-abusing persons. The general conclusion is that the family of origin does not adequately equip some of its members to assume adult responsibilities, thereby contributing to drug addiction. Chein et al. (1964) found that drug users' families have greater weaknesses than do other families. Studies by McCord (1965), Aron et al. (1976), Ellinwood et al. (1966), Chambers et al. (1968), and Wolk and Diskind (1961) all show links between family disorganization and addiction.

Chein et al. (1964), in their study of young male addicts, wanted to understand why some individuals in marginal communities became addicted and others did not. They found the critical factor to be "the degree of family emotional health, with the mother's relationships especially crucial." Other authors have also found the addicts' relationships with their mothers to be of special importance. Mason (1958), in his clinical work with adolescent and young adult drug addicts in New York City, found certain factors to be recurrent, stating, "The father of the addict is usually either physically absent through death, separation, or

work away from home; or he represents a shadowy background figure. . . . The mother, on the contrary, is the "boss," and is always present--if not in person--exerting her influence upon the patient even when removed from him physically." To the addicts seen as patients by Mason, the mother was always the preferred and the important parent. Rosenfeld (1962) also found the mother to be a central figure in the family of the drug addict. She describes the mother as "an immature parent who vacillates between possessiveness and frank rejection." Again, Rosenfeld found the father to be a remote, detached figure.

Gerard and Kornetsky (1954) describe an ambivalent relationship between an addict and his mother, with regressive, manipulative, and seductive overtones. Chein et al. (1964) categorized the mothers of female adolescent drug addicts as "insecure . . . judgmental, rigid, authoritarian . . . punitive or indifferent in regard to their daughters' sexual functions and development." The mother of the drug addict is described as the domineering parent in Vaillant (1966), Laskowitz (1965), Frazier (1962), Fort (1954), Nyswander (1956), Gissin et al. (1960), and Hirsch (1961). Most of the drug literature refers to mothers of male addicts and a "peculiar" mother-son relationship.

The female figure is often dominant because the family of the drug addict is usually characterized as a one-parent or father-absent household where the mother must take the lead to survive. Johnston (1968), in a study of 100 convicted female narcotic residents, found that 65 percent of the sample had parents who had separated during their formative years. Aron (1975) found that nearly one-half of the sample (44.5 percent) came from homes where one or both of the biological parents were absent due to death, separation, or divorce. In a study by Aron and Daily (1976), only 53 percent of a primarily white, west-coast sample were raised with biological parents. Other studies have reported sex and race differences in rates of parental separation for drug addicts. Ellinwood et al. (1966) found that separation of the parents of women occurred at an earlier age than that of males. Chambers et al. (1970) found that the majority (54.8 percent) of the female addicts in their sample had been reared in a home which had been broken prior to their reaching age 16. Collier et al. (1972), Baer and Corrado (1974), Osnos and Laskowitz (1966), Merry (1972), and Willis (1969) also found broken homes to have an influence on the development of drug addiction.

Personal trauma, which includes incest, rape, violence, death by drug overdose, and attempted suicides, are also hypothesized in the drug treatment literature to be more prevalent in families of drug addicts. Aron in his 1975 study makes the case that a greater number of those events occur in the families of drug addicts. Benward and Densen-Gerber (1975) suggest that mothers in families of drug addicts will rarely take action against their husbands to protect their children. Ellinwood et al. (1966) found 10 percent of the sample involved sexually with the father and 13 percent involved sexually with a stepfather, relative, or mother's lover.

Drug or alcohol use in the family of origin is also seen as a precipitating factor in later drug addiction in the child. Robins et al. (1967) showed a correspondence between parental drug dependency (alcoholism) and sociopathy and alcoholism in the offspring. Cahalan (1970) found that high-risk drug users came from families who use and value alcohol, and where there is a permissive and supportive climate for other drug use. Blum and Associates in 1970 and 1972 found parents' drug use to have an effect on their children's later drug use. Their 1970 study reported that 40 percent of opiate users reported that their parents also used opiates.

Few studies have compared drug users with nondrug users. Craig and Brown (1975) looked at youthful male heroin users and nonusers and found users were significantly less likely than nonusers to have both parents available to them in formative years--the major difference between the two groups during these years. A study by Glaser et al. (1971) of siblings in low-income areas of New York City indicated that addicts were not in conflict with their parents more often nor were they more alienated from their parents than their nonaddicted siblings. However, they (Glasser et al. 1971) also found that addicts did poorly in school, had more difficulty holding jobs than their nonaddicted siblings, and were more involved in street life, gang activities, arrests, and a hustler lifestyle.

This study looks more closely at differences in psychosocial functioning of the families of origin of heroin users and nonusers. A better understanding is needed of the differences in family dynamics that contribute to drug use by certain people but not by others of similar backgrounds. Most of the drug treatment literature, especially in the area of background characteristics, looks only at male addicts. This study is an attempt to bridge a serious gap in the literature by focusing on background characteristics of female heroin users and a similar comparison group of nonusers. Little is known about the female drug user as compared to her nondrug-using peer, and until recently many public and professional assumptions have been tempered by myths and assumptions. This research focuses on psychosocial aspects of the family of origin of the female heroin user and nonuser. Her family structure, her relationship with her parents, her attitudes about her childhood, and her attitudes about herself while growing up will be explored.

METHOD

Subjects

The addicted women (n=73) were enrolled in drug treatment programs in low-income areas in Detroit, Michigan. A comparable socioeconomic sample of comparison women (n=175) were recruited from a Michigan Employment Security Commission (MESC) branch office that draws from similar low-income, inner-city communities

in Detroit. The approximate age of the women in both the addicted and nonaddicted sample was 25 years. Approximately 80.8 percent of the addicted sample were black and 19.2 percent white. The nonaddicted sample was 70.7 percent black, 26.4 percent white, and 2.9 percent other. Racial differences between the groups are not statistically significant. The comparison women were more likely to have graduated from high school than the addicted women (table 1 of "Introduction").

Procedure

Questionnaires containing demographic, situational, and psychosocial information were administered in personal interviews to women in drug treatment programs and to comparison women in Detroit. The social history section of the questionnaire covered six general areas: living arrangements, perceptions of significant others, family interaction patterns, child-rearing experiences, religious experiences, and self-perceptions as a child. Comparison women were not asked questions dealing with drug treatment and were only asked questions on their general feelings about the use of alcohol, medicine, and other drugs.

A more detailed description of the methodology, instrument development, sample selection, and demographic characteristics of the groups is presented in the introduction.

RESULTS

Family Organization,
Interaction, and Relationships

Living arrangements and economic conditions. A majority of both groups of women lived in a large city from birth to 16 years of age. As the findings in table III-1 indicate, addicted women were significantly more likely to have lived in Michigan from birth to 16 years of age, while comparison women were much more likely to have lived in the South. In fact, none of the addicted women lived in the South after they reached the age of 12.

The households of neither group moved very often before the women were 16 years old; approximately 50.9 percent of the comparison women moved once or less, and 58.9 percent of the addicted women moved twice or less. Both groups grew up in a stable environment, with 58.6 percent of the addicted women and 61 percent of the comparison women living in the same neighborhood for 10 years or more. When asked to choose from a pair of descriptions about their neighborhood while growing up, 72.6 percent of the addicted women and 82.3 percent of the comparison women reported that "My neighborhood stayed pretty much the same. We didn't move around much and our neighbors didn't move much." When asked to choose from another pair of descriptions about their living situations while growing up, 87.7 percent of the addicted women and 93.1 percent of the nonaddicted women

TABLE III-1. —Location of resident from birth to 16 years (in percent)

	Addicted (n=72-73)	Comparison (n=174-175)	χ^2 (d.f.=3)
Before 12 years			[1]8.47
Michigan	84.9	68.0	
North	5.5	11.4	
South	6.8	18.3	
Other	2.7	2.3	
From 12 to 16 years			[2]16.17
Michigan	93.2	72.0	
North	5.5	9.7	
South	--	16.6	
Other	1.4	1.7	
Over 16 years			N.S.
Michigan	91.7	82.8	
North	5.6	7.5	
South	--	8.0	
Other	2.8	1.7	

[1] $p < 0.05$.

[2] $p < 0.001$.

reported that "I lived with the same people most of the time while I was growing up. My family and the people living with us stayed pretty much the same."

Both groups of women were raised in similar family constellations until they were 12 years old. The "other kin situations" category in table III-2 includes living arrangements with father only, father and stepmother, grandmother only, grandparents, brother, and other relatives. While the addicted woman is more likely to have lived with her mother and a stepfather, the comparison woman is more likely to have lived only with her mother. The majority of both groups, however, lived with both parents. The size of the household was also similar for both groups while they were growing up. Approximately 61.4 percent of the addicted women grew up in households with two to five members, and 67.4 percent of the comparison women were raised in households with one to six members.

When the women were asked to describe family members they lived with and to tell how close they were to each person named, some similar findings emerged. Both groups described their parents

TABLE III-2.—Family constellation of addicted and comparison women until 12 years of age (in percent)

Living arrangements	Addicted (n=73)	Comparison (n=175)
Mother	23.3	32.0
Both mother and father	47.9	54.9
Mother and stepfather	12.3	2.3
Other kin situations	11.0	9.2
Institution/foster care/other	5.5	1.7

$\chi^2(11)=19.49$, $p < 0.05$.

and indicated that they were "very close" to them. Table III-3 shows the total number of siblings of the two groups. The addicted and the comparison women had a like number of male and female siblings. In the descriptions of family members who lived with them, the overwhelming majority of both groups said they were "very close or somewhat close" to their siblings.

The women in both samples were reared in similar economic circumstances. Table III-4 shows the differences in the women's descriptions of their families' economic situations. The women were fairly equally distributed across categories with comparison women slightly more likely to report the extreme conditions. That is to say, the addicted women were not significantly more likely to have been impoverished during childhood. These results are an interesting departure from those in the existing literature (Feldman 1968; Holzner and Ding 1973).

Family Interaction

How well did the adults in the families of the two groups of women get along with each other? Responses of the two groups on that item were not significantly different. The overwhelming majority of both groups (70.2 percent of the addicted women and 79.6 percent of comparison women) perceived the adults at home as getting along "fairly well or very well."

Both groups had active family lives while growing up, with regular family get-togethers where everyone, including grandparents, was present. Small but significant differences were found in the reasons for the family members' getting together for special times during the week. Approximately 7.4 percent (n=68) of the comparison women reported family celebrations--weddings, birthdays,

TABLE III-3.—Total number of siblings

	Addicted (n=72)	Comparison (n=174)
Sisters		
Total	2.0	2.1
Full	1.3	1.6
Brothers		
Total	2.0	2.1
Full	1.6	1.8
Total siblings	4.0	4.2
Total full siblings	3.1	3.6

Differences not significant.

TABLE III-4.—Family's economic situation (in percent)

Economic description	Addicted (n=73)	Comparison (n=174)
A. You were poor and had a hard time getting enough money to buy food or pay the rent.	2.7	8.0
B. You were poor but usually had enough money to buy food and pay the rent.	38.4	32.2
C. You had a better steady income, could always pay for food and rent, and did not consider yourselves poor.	45.2	39.7
D. You had a pretty good income and were able to buy extras and special things when you wanted them.	13.7	20.1

Differences not significant.

graduations, retirement, christenings--as special times, while none of the addicted women (n=62) reported such celebrations [χ^2 (9)=18.52, p 0.03]. The special times were more likely to be calendar events (e.g., holidays, Christmas, Sunday) for addicted women (54.8 percent) than for comparison women (33.8 percent).

Descriptions of family life while growing up did not reveal any significant differences between the addicted and comparison women. As table III-5 indicates, the majority of both groups of women were mostly or sometimes happy. Family interactions for both groups of women seem to have been basically happy, economically steady, with a great deal of intermingling in their domestic networks.

TABLE III-5.—Description of family life (in percent)

	Addicted (n=70)	Comparison (n=173)
Mostly happy	45.7	46.2
Sometimes happy	31.4	33.5
Sometimes unhappy	10.0	14.5
Mostly unhappy	12.9	5.8

Differences not significant.

Relationship with Parents

The important significant others in a child's life are his/her parents. Results presented earlier indicated that the majority of both groups of women were raised by both parents until they were 12. It is important to explore the women's perceptions of their parents.

As indicated in table III-6, there are significant differences in the educational level attained by the fathers of the addicted and comparison women. The fathers of the comparison women were more likely to have gone beyond high school. The fathers of the addicted women are a little more likely to have gone only to grade school or to have had some high school. Another striking difference is that the addicted women are a little more than twice as likely not to know the level of the father's education.

As shown in table III-7, there are also significant differences in the educational levels of the women's mothers. The mothers of

TABLE III-6.—Father's education (in percent)

	Addicted (n=53)	Comparison (n=140)
Did not go to school	--	--
Went to grade school	37.7	32.9
Had some high school	22.6	19.3
Was a high school graduate	17.0	19.3
Had some schooling beyond high school	--	12.9
Was a college graduate	3.8	7.1
Doesn't know	18.9	8.6

$\chi^2(5)=11.68$, $p < 0.04$.

TABLE III-7.—Mother's education (in percent)

	Addicted (n=72)	Comparison (n=171)
Did not go to school	5.6	1.2
Went to grade school	19.4	18.7
Had some high school	36.1	25.7
Was a high school graduate	16.7	28.1
Had some schooling beyond high school	11.1	13.5
Was a college graduate	1.4	7.6
Doesn't know	9.7	5.3

$\chi^2(6)=13.67$, $p < 0.03$.

the comparison women are more likely to be high school or college graduates than are the mothers of the addicted women. A majority of the mothers of the addicted women have had some high school. In contrast to the number of addicted women who did not know the level of the father's education, more addicted women knew about their mother's educational attainments, even though the percentage in that category is still higher than for the comparison sample.

There were no significant differences in the kinds of jobs usually held by the mothers or fathers of the two samples of women. Using the coding categories from the classified index of industries and occupations (U.S. Department of Commerce 1970), most of the jobs usually held by both parents would be considered "blue collar" jobs.

Approximately 27.8 percent of the addicted women and 18.3 percent of the comparison women had someone they thought of as a mother or father leave home. The majority of the women in both samples reported not losing a parent to death before they were 12 years old. When asked, "Before you were 12 years old, did anyone in your family whom you were close to die," 16.7 percent of the addicted women reported "mother," and 25 percent reported "father" (n=24). A smaller number, 11.5 percent (n=78), of comparison women reported "mother," and 7.7 percent reported "father." The differences in these responses were not significantly different. The women in both samples mention a grandparent most often as the family member who died before they were 12--33.4 percent of the addicted women and 50 percent of the comparison women. So, while the addicted women were a little more likely to lose a father to death before they were 12 years of age, the differences in the two samples of women having a mother or father die or leave for good or for a long time were not significant.

A semantic differential scale describing the parents of the women in the two samples revealed no significant differences in the women's perception of the their parents. Pairs of words, like "helpful/unhelpful" and "cold-acting/warm-acting," were included in a list of 15 adjective pairs. A t-test on the differences in the responses for the addicted and comparison samples showed no significant differences in the descriptions of their mothers or their fathers. The majority of both the addicted and the nonaddicted women found their mothers and fathers to be helpful, fair, strict, loving, openminded, smart, fun, understanding, and easy to get along with. Approximately 47.4 percent of the comparison and 45.1 percent of the addicted women felt they had a "good mother." Thirty-nine percent of the nonaddicted and 36.2 percent of the addicted women perceived their father as a "good father."

However, a pairwise t-test on the differences in the women's description of their parents did indicate significant differences. As shown by the results in table III-8, the addicted women and the comparison women described their mothers in significantly more positive terms than they did their fathers.

TABLE III-8. —A pairwise comparison of semantic differential descriptions of mother and father

	Mean	Standard deviation	*t*-stat
Addicted women (n=57)			
Mother description	72.719	29.520	[2]2.6517
Father description	62.351		
Comparison women (n=140)			
Mother description	73.300	23.378	[1]2.4149
Father description	68.529		

[1] $p < 0.02$.

[2] $p < 0.01$.

Another indicator of the relationship the women in the two samples had with their parents is in the ways they perceive themselves as being like them. When asked how they are like their mothers, the women mentioned neutral physical characteristics (e.g., look alike, have same hair), positive personality traits and emotionality (e.g., both are smart, good listeners, relaxed, easy-going), neutral personal traits (e.g., independent, shy, worry about others, emotional, moody, strong-willed), or said they are not like their mothers. When asked how they were like their fathers, both groups of women stressed positive or neutral physical and personality traits. When queried on how they were not like their mother or father, the responses were relatively undifferentiated for a substantial portion of both groups.

Given the favorable perceptions both groups of women have of their parents, it is interesting to see what kinds of things they enjoyed doing with their parents while growing up. Both groups enjoyed cooking, sewing, gardening, and, to a lesser extent, shopping with their mothers. In contrast, however, many of the women in both groups said there was nothing or little they did with their fathers, though a small percent said they liked to engage in active sports.

What were some of the special things the parents of the two groups of women did for them? Approximately 35.2 percent of the parents of the addicted women bought special things like toys or gifts; 25.4 percent sewed, cooked, or built things for the child; and 9.9 percent prepared special events such as birthday parties. Approximately 41.4 percent of the parents of the non-addicted women bought special things like gifts or toys; 21.8 percent made, sewed, cooked, or built things; and 13.8 percent

prepared special events such as birthday parties. Clearly the majority of the women in both samples enjoyed happy, stable, activity-filled relationships with both their mothers and fathers while growing up. The women in both samples also viewed their parents and their relationships with them with warm memories.

SOCIALIZATION ISSUES

Punishment and Discipline

Punishment and discipline are areas of great speculation in the background characteristics of addicted women. There were major differences in the way the two groups of women were disciplined. As table III-9 shows, the addicted women were more likely to be punished by being made to do extra work, being given a lecture, not being allowed to go somewhere or do something they wanted to, and being screamed and yelled at. The comparison women were a little more likely to be grounded or made to stay home as a punishment, but this difference was not significant. A scale developed from a combination of items referring to the woman's perception of rigidity and punishment in her upbringing showed no differences between the groups.

TABLE III-9.—Punishment and discipline (in percent)

Type of punishment	Addicted (n=73)		Comparison (n=174-175)		
	Yes	No	Yes	No	χ^2(d.f.=1)
Spankings or whippings	82.2	17.8	74.9	25.1	N.S.
Made to do extra work	15.1	84.9	5.7	94.3	[1]5.82
Given a lecture on what I had done wrong	31.5	68.5	18.9	81.1	[1]4.72
Not allowed to go someplace or do something I wanted to do	67.1	32.9	42.3	57.7	[2]12.71
Screamed and yelled at	23.3	76.7	12.6	87.4	[1]4.38
Some other way (sent to bed, room, or corner)	5.5	--	6.9	--	N.S.
Grounded, made to stay home	2.7	--	6.3	--	N.S.

[1] $p < 0.05$.

[2] $p < 0.001$.

Compared to other children they knew, how often were the women in the two samples punished? As table III-10 shows, there were small differences in the perceptions of the two samples. The addicted women were more likely to feel that they were punished much more than other children, while the nonaddicted women felt they were punished not nearly as often or about as often as other children.

TABLE III-10.—Amount of punishment compared to others (in percent)

	Addicted (n=72)	Comparison (n=175)
Not nearly as often as other children	30.6	35.4
About as often as other children	40.3	45.7
Much more than other children	29.2	18.9

Differences not significant.

The figures in table III-11 indicate that there were no significant differences between addicted and comparison women regarding their feelings about being punished. However, slightly more addicted women than comparison women fear that they were frequently punished for no reason. Among the addicted women, significantly more of them stated that they were never punished without a reason.

TABLE III-11.—How often punished for no reason (in percent)

	Addicted (n=73)	Comparison (n=175)
Never	42.5	40.0
Hardly ever	28.8	36.6
Sometimes	17.8	20.0
A lot of the time	8.2	2.3
Most of the time	2.7	1.1

Differences not significant.

Childhood Responsibilities

What types of techniques were used to assist the women in the two samples in learning responsibilities that would prepare them for adulthood? An overwhelming majority of both the addicted women (89 percent) and the comparison women (87.4 percent) had special jobs, work, or chores around the house that they had to do as a child. There was only one major difference in childhood earnings, as illustrated in table III-12. Addicted women were significantly more likely to have "hustled" to get money when they needed it while growing up. The only other major source of money for both groups of women was an allowance.

TABLE III-12.—How to get money when needed (in percent)

	Addicted (n=73)		Comparison (n=175)		χ^2
	Yes	No	Yes	No	(d.f.=1)
Asked adults for it	72.6	27.4	68.0	32.0	N.S.
Worked for it	27.4	72.6	29.1	70.9	N.S.
Hustled	4.1	95.9	--	100.0	[1]7.28
Some other way					
Given as gift by adults	4.1	--	4.6	--	N.S.
Allowance	15.1	--	18.3	--	N.S.

[1] $p < 0.01$.

Leaving Home in Childhood

The differences in the age at which the two samples of women were first allowed to go out alone were not statistically significant. Approximately 59.1 percent of the comparison women were allowed to go out alone for the first time between the ages of 8 and 13, while 64.5 percent of the addicted women in the same age range went out alone. The average age at which the women were first allowed out alone was 11.40 years for addicted and 10.35 years for comparison women, showing earlier independence for comparison women.

Running away from home as a child often indicates unhappiness or a troubled home environment. As table III-13 shows, the women in the two samples were asked if they had ever run away or left home before they were 16 years old. The addicted women were much more likely to have run away from home before 16. Comparison women were more likely to have run away from home once or twice, while addicted women were more likely to have run away

TABLE III-13.—Running away from home (in percent)

	Addicted (n=73)		Comparison (n=175)		χ^2
	Yes	No	Yes	No	(d.f.=1)
Ran away	56.2	43.8	23.4	76.6	[1]24.94

[1]$p < 0.001$.

twice or more (table III-14). About 97.5 percent of the addicted women and 97.4 percent of comparison women left home on their own as opposed to being put out by someone. As table III-15 shows, when they left home the majority went to the homes of friends or relatives. The comparison women were more likely to go to their other parent or to another relative's home, while the addicted women were much more likely to go to a friend's place. None of the differences in destination when they left home were statistically significant.

TABLE III-14. —2-sample comparison of the number of times ran away from home

	n	Mean	*t*-stat
Addicted	41	3.1220	--
Comparison	39	2.1282	[1]2.1446

[1]$p < 0.05$.

Leaving the family of origin to become a member of the adult world is a difficult though necessary process. Teaching the child to accept adult responsibility is one of the major socialization obligations of the family. The age at which women in the two samples left the family of origin shows some interesting and significant differences. As table III-16 indicates, the addicted women were more likely to have left home for good at 18 years of age or younger, while the comparison women were more likely to have left at 18 years of age or older. In fact, even though both groups are the same age, comparison women are three times as likely to still live at home. Table III-17 shows that women in both groups leave home for a variety of reasons.

TABLE III-15.—Where did you go when you left home? (in percent)

	Addicted (n=41)	Comparison (n=46)
To other parent	--	7.5
To relatives besides other parent	17.1	25.0
To a friend's place	56.1	35.0
To a boyfriend's place	9.8	5.0
Hung out on street, in neighborhood, backyard	12.2	15.0
Traveled	2.4	7.5
To institution or professional helping person	2.4	2.5
Other	--	2.5

Differences not significant.

TABLE III-16.—How old were you when you left home for good? (in percent)

	Addicted (n=72)	Comparison (n=173)
10 to 16 years	16.7	7.5
17 years	23.6	11.6
18 years	30.6	22.5
19 to 22 years	18.0	27.0
23 years and above	2.8	6.5
Still lives at home	8.3	24.9

$\chi^2(15)=26.25$, $p \geq 0.05$.

TABLE III-17.—Why did you leave home? (in percent)

	Addicted (n=66)	Comparison (n=129)
Got married, moved in with partner	37.9	30.2
Had own place	3.0	3.1
Moved in with other relative	--	3.1
Moved to another place or city	3.0	1.6
Grown up, got job, self-sufficient	1.5	7.8
Had problems at home, unhappy at home, differing opinion, rules	18.2	16.3
Felt it was time to leave, ready for place of their own	22.7	17.8
Joined armed services	--	1.6
School or college	3.0	13.2
Put out	--	.8
Pregnant	4.5	1.6
Home environment changed (e.g., parent remarried)	1.5	3.1
Other	4.5	--

$\chi^2(12)=20.90$, $p < 0.05$.

Religious Experience

Most women in both samples attended church or Sunday school while growing up. Addicted and comparison women were equally likely to attend church very often--69.9 percent and 74.1 percent, respectively. Findings also indicate that the families of both groups were religious (79.5 percent of the addicted women and 82.7 percent of the comparison women reporting that their families were "very" or "fairly" religious). Approximately 57.7 percent of the comparison and 39.9 percent of the addicted women said that they had some kind of religious experience since they were 12 years old [χ^2 (1)=6.68, $p < 0.01$]. When asked to describe the religious experience, 82 percent of the comparison and 86.2 percent of the addicted women said they were baptized, joined the church, or were confirmed.

Self-Perceptions as a Child

The abilities, attitudes, and perceptions of the two groups of women during childhood were investigated. In general, the

majority of the women in both samples perceived themselves as being "good kids." But, as table III-18 shows, the addicted women were significantly more likely to describe themselves as "bad kids."

TABLE III-18.—Self-description as a child (in percent)

	Addicted (n=72)	Comparison (n=174)
Good kid	81.9	93.1
Bad kid	18.1	6.9

$\chi^2(1)=6.95$, $p < 0.01$.

As shown by the findings in table III-19, both groups of women had fairly positive feelings during childhood and adolescence. The overwhelming majority of the women felt wanted during childhood. These descriptions of feelings of happiness during childhood change very little from childhood to adolescence.

TABLE III-19.—Happiness during childhood (in percent)[1]

	Very often or sometimes		A few times or never	
	Addicted (n=73)	Comparison (n=173-174)	Addicted (n=73)	Comparison (n=174-175)
Before 12 years old				
Lonely	54.8	48.6	45.2	51.4
Unloved	39.7	31.6	60.3	68.4
Wanted	80.8	83.9	19.1	16.1
12 to 16 years old				
Lonely	52.0	47.7	48.0	52.3
Unloved	42.5	37.0	57.5	63.0
Wanted	78.1	81.7	21.9	18.3

Differences not significant.

[1] "Very often and sometimes" responses and "a few times and never" responses were collapsed.

The overwhelming majority of both the addicted women, 75 percent, and the comparison women, 74.7 percent, had as many friends as they wanted during childhood. Most of both groups (72.2 percent of the addicted and 78.7 percent of the comparison) also had an "easy time" making friends. It is interesting to note that 82 percent of the addicted women and 80 percent of the comparison women reported that they "pretty much had the same friends for years."

As indicated by the data in table III-20, most of the women in both samples felt popular with people their own age before 12 years old. Most of both groups, though more of the addicted women, felt popular with boys around their own age from 12 to 16 years old. Both groups of women also felt popular with girls around their own age during the same period. Embarrassment or feeling out of place was felt only a "few times or never" by approximately two-thirds of the women in the sample before 12 years and from 12 to 16 years old.

An overwhelming majority of the women in both samples "felt there were some things they were really good at, that other people admired or looked up to them for" during their childhood. In the comparison sample, 80.6 percent reported "being really good at something," and 84.9 percent of the addicted women reported the same. Women in both samples were good at activities across various skill areas. Dance was mentioned most frequently by both groups, while sports was the second mention for addicted women, and music and singing were the second mention for comparison women. Both groups mentioned cooking and baking as third activities. These same activities were chosen most frequently by both groups as "things they really enjoyed doing--whether or not they were good at them." On the whole, most of the women in both samples were engaged in special activities that they felt they were good at with active sports, dance, cooking, and music as areas of greatest interest to both while growing up.

Student Self-Perceptions

School is an area where important interpersonal interactions take place and where mastery and self-esteem are crucial. In general most of the women liked school, with approximately 68.5 percent of the addicted and 76.4 percent of comparison indicating a liking for school. The most frequently chosen reasons why addicted women liked school while growing up was because they "enjoyed classes" (33.3 percent), "it was something to do" (11.1 percent), and they "got to be with friends" (9.7 percent). Respective percentages for the comparison women for the same reasons were 24.7 percent, 14.9 percent, and 22.4 percent (differences not significant).

As shown in table III-21, most of the women in both groups thought of themselves as "average" or "good" students.

The women in both samples perceived themselves as being "really good" in some of the same things at school, with most in both

TABLE III-20.—Feelings about friendships during childhood (in percent)[1]

	Very often or sometimes		A few times or never	
	Addicted (n=73)	Comparison (n=171-175)	Addicted (n=73)	Comparison (n=171-175)
Before 12 years old				
Popular with people your own age?	78.1	79.3	21.9	20.6
Embarrassed or out of place when you were with a group of people your own age?	37.0	34.2	63.1	65.8
12 to 16 years old				
Popular with boys around your own age?	84.9	72.5	15.0	27.5
Popular with girls around your own age?	76.7	80.0	23.3	20.0
Embarrassed or out of place when you were with a group of people your own age?	38.4	33.1	61.6	66.9

Differences not significant.

[1]"Very often and sometimes" responses and "a few times and never" responses were combined.

TABLE III-21. —Type of student during childhood (in percent)

	Addicted[1]	Comparison[2]
Bad or poor	8.2	4.6
Average	46.6	60.0
Good	45.2	35.4

Differences not significant.

[1] n=73.

[2] n=175.

groups mentioning gym/sports, English literature, arts, and mathematics.

Although similar in the courses they liked at school, the comparison women were significantly more likely than addicted women to have had a teacher who treated them as special. Approximately 78.5 percent of comparison women and 57.5 percent of addicted women had a teacher who treated them as special [χ^2 (1)=11.22, $p < 0.001$]. This teacher was most likely to treat the comparison women as special by going out of her/his way for the respondent (24.6 percent, n=134), by assigning special jobs or responsibilities (17.9 percent), or by giving the respondent special advice or listening to her problems (17.2 percent). Special treatment for addicted women consisted of the teacher's going out of her/his way for the respondent (23.8 percent, n=42), extra academic help (16.7 percent), or general support and recognition [14.3 percent, $\chi^2(13)=24$, $p < 0.05$].

Although the majority of the women in both the addicted and comparison samples "liked school," and felt they were "average or good" students, those perceptions by the addicted women did not seem to significantly impact on their retention in high school (table III-22). The addicted women were more than twice as likely to leave school without a high school diploma. The major reasons addicted women left school, as shown in table III-23, were because "they were bored or tired," "did not like courses," and "did not get along well" with teachers or other school officials.

Although there are some striking differences in the reasons the two samples of women left high school, there was a significant difference regarding only one reason--being on drugs. The women who left high school in the two samples did so for somewhat differing reasons. Clearly, drug use while in high school was a critical determinant in the lack of retention of the addicted women.

TABLE III-22.—Leaving high school without a diploma (in percent)

	Addicted[1]		Comparison[2]	
	Yes	No	Yes	No
Did you leave school before getting your high school diploma?	71.2	28.8	26.9	73.1

$\chi^2(1)=42.29$, $p < 0.001$.

[1] $n=73$.

[2] $n=175$.

TABLE III-23.—Reasons for leaving high school without a diploma (in percent)

	Addicted (n=51-52)		Comparison (n=47)		χ^2
	Yes	No	Yes	No	(d.f.=1)
Money problems	9.6	90.4	21.3	78.7	N.S.
Didn't like courses	25.0	75.0	10.6	89.4	N.S.
Didn't get along with other students	7.7	92.3	10.6	89.4	N.S.
Didn't get along with teachers/other school officials	19.2	80.8	14.9	85.1	N.S.
Bored or tired of school	57.7	42.3	46.8	53.2	N.S.
Your family wanted or needed you at home	2.0	98.0	10.6	89.4	N.S.
Family didn't think you needed an education	5.8	94.2	4.3	95.7	N.S.
On drugs	13.5	86.5	2.1	97.0	[1]4.27
Pregnant	32.7	--	17.0	--	N.S.
Got married	5.8	--	10.6	--	N.S.
Other	11.5	--	2.1	--	N.S.

[1] $p < 0.05$.

As shown in table III-24, there were also some differences in the "most important reason" for leaving high school without a diploma. Both comparison and addicted women who left high school without a diploma cited boredom with school or being pregnant and/or having children as the primary motives. The comparison women had a broader range of reasons they considered most important, but none of the differences between groups was significant.

DRUG USE AND FAMILY PROBLEMS

Problems of Family Members

Problems of family members, including drug problems, were investigated for both the addicted and comparison women. They were asked to "tell whether anyone in your family did any of these things while you were growing up." As shown by table III-25, family members of addicted women are more likely to have drinking problems. The occurrence of other problems in table III-25 was similar for the two groups of women.

Comparison Women's Feelings About Drug Use

The comparison women in the sample were questioned only on their general feeling about the use of alcohol, other medicines, or drugs. They were likely to feel that there had been problems in their family because some other family member drank alcoholic beverages many times or sometimes. In fact, as shown in table III-26, approximately 48 percent of the women felt many times or sometimes that problems had occurred because of a family member's drinking. A small percentage of the women (26.9 percent) indicated that they, too, sometimes drank more than they should. Other than these two areas, the comparison women never or hardly ever used medicines, drugs, or alcoholic beverages. When asked if they were in treatment for alcohol abuse, all indicated that they were not, and 99.4 percent indicated they were not in drug treatment. It is interesting to note in table III-26 that the comparison women felt that many times or sometimes there had been problems because a family member drank. Although the family members of these women had drinking problems sometimes, they were still less likely than the addicted women to say a family member "drinks a lot."

Drug Use by Addicted Women

Eliminating alcohol and cigarettes, the drug tried first most often by the addicted women in this sample was marijuana (table III-27), followed by heroin, barbiturates, amphetamines, and THC. The majority used their first drug between 14 and 18 years of age (table III-28) and were most likely offered drugs for the first time by a friend (43.8 percent), a partner or boyfriend (12.3 percent), or friends (11 percent). For the first drug tried, 39.7 percent of the respondents indicated that a female and 67.1

TABLE III-24.—Most important reason for leaving school (in percent)

Category	Addicted (n=52)	Comparison (n=43)
Money problems	--	11.6
Bored, tired of school	23.1	23.3
Family wants or needed you at home	--	11.6
Didn't like courses	1.9	--
Pregnant, children	30.8	14.0
Got married	5.8	11.6
Kicked out	5.8	2.3
Didn't get along with other students	1.9	4.7
Moved	1.9	4.7
Respondent thought she didn't need school	3.8	--
You were on drugs	5.8	2.3
Sick/in accident	3.8	2.3
General financial problems	1.9	2.3
Had to care for family, parent died	1.9	2.3
Others didn't care about respondent	--	2.3
Behind in studies	1.9	22.3
Other	9.6	2.3

Differences not significant.

TABLE III-25.—Problems of family members (in percent)

	Addicted (n=72)		Comparison (n=174-175)		
	Yes	No	Yes	No	χ^2
Use drugs	20.8	79.2	18.9	81.1	N.S.
Drinks a lot	59.7	40.3	42.9	57.1	[1]5.82
Serve a jail sentence	16.7	83.3	20.1	79.9	N.S.
Have a nervous breakdown or was thought of as crazy	22.2	77.8	17.2	82.8	N.S.
Have a bad illness for a very long time	38.9	61.1	34.9	65.1	N.S.
Try to involve you in drug use	5.6	94.4	2.9	97.1	N.S.
Try to involve you in helping to get money by illegal means	4.2	95.8	1.1	98.9	N.S.

[1]$p < 0.05$.

TABLE III-26.—Comparison women's use of medicines and substances (in percent)[1]

	Never	Hardly ever	Some-times	Many times
Do you ever drink more than you should?	50.3	20.6	26.9	2.3
When you feel worried, tense, or nervous, do you ever drink alcoholic beverages to help you handle things?	70.9	15.4	12.0	1.7
Have there ever been problems between you and anyone in your family because you drank alcoholic beverages?	89.1	5.2	3.4	2.3
Have there ever been problems in your family because some other family member drank alcoholic beverages?	44.6	7.4	28.0	20.0
When you feel worried, tense, or nervous, do you ever take medicines or drugs to help you handle things?	78.3	8.0	10.9	2.9

[1] n=174-175.

TABLE III-27.—First drug used by addicted women (in percent)

	n=72		n=72
Marijuana	44.4	Methamphetamine	1.4
Heroin	25.0	Cocaine	1.4
Barbiturates	9.7	Hashish and hash oil	1.4
Amphetamines	8.3	LSD (lysergic acid diethylemide)	1.4
THC	4.2		
Secobarbital	1.4	Nonnarcotic cough sirups	1.4

TABLE III-28.—Age of addicted women for first drug used (in percent)

	n=72
11 to 12 years old	6.8
13 to 14 years old	24.6
15 to 16 years old	27.4
17 to 18 years old	20.6
19 to 20 years old	10.6
20 years or older	9.6

percent that a male offered them the drug. (The categories are not mutually exclusive.)

Table III-29 shows ages of women when they first tried heroin. The percent for first use is higher for 21 years old or older because some addicted women in this sample used heroin for the first time as late as age 32. A friend, partner, or boyfriend are equally likely (27.4 percent) to be the first person to offer the addicted women heroin the first time. Friends (12.3 percent) and a male friend who was not a lover or boyfriend (9.6 percent) were the next most frequently mentioned people. For the first heroin use, 28.8 percent of the respondents indicated that a female and 75.3 percent that a male offered them the heroin. (The categories are not mutually exclusive.)

TABLE III-29.—Age of addicted women when first tried heroin (in percent)

	n=73
13 to 14 years old	9.5
15 to 16 years old	17.8
17 to 18 years old	31.5
19 to 20 years old	13.7
21 years or older	27.4

Approximately 54.3 percent of the women reported trying heroin the first time it was offered, and approximately 46.6 percent began using drugs regularly between 17 and 20 years of age. The addicted women were also asked if they had used any of the substances listed in table III-30 so that they would be accepted by others. There seemed to be more pressures on the addicted women to conform to the use of marijuana and drugs.

TABLE III-30.—Addicted women's use of substances or sex for acceptance (in percent)[1]

Substance	Yes	No
Smoke cigarettes	38.6	61.4
Drink alcohol	27.1	72.9
Have sex	24.3	75.7
Smoke marijuana	48.6	51.4
Take drugs	45.7	54.3

[1] n=70.

What are the reasons the addicted women in this sample use heroin? As shown in table III-31, most of the addicted women use primarily to forget problems, escape from reality and/or frustrations, because they enjoy it, and because they are around people who use drugs. As the results in table III-32 indicate, "to help me forget my problems" is the most important reason the addicted women in the sample use heroin, followed by enjoyment and parental hassles.

TABLE III-31. —Addicted women's reasons for using heroin (in percent)

	n=73		n=73
Forget problems, escape reality	28.8	I like it, it feels good	27.4
Nerves, anxiety, depression	2.7	Curiosity, experiment	11.0
Weakness	4.1	To please a man, it enables one to interact with others	5.5
Environment, being around people who use drugs	13.7	Addiction, avoid withdrawal symptoms	2.7
		Other	4.1

TABLE III-32. —The most important reason addicted women use heroin (in percent)

	n=73
To help me forget my problems	23.3
To feel good	21.9
Because of hassles from my parents	13.7
To please a man I was close to	8.2
To avoid getting sick	6.8
To please a woman I was close to	2.7
Because of physical pain or illness	2.7
Because of tension or nervousness	2.7
Because of feeling down or disappointed	2.7
To be hip	2.7
Escape from reality	2.7
I like it	2.7
Nerves, anxiety, depression	1.4
Curiosity, experiment	1.4
To loosen up in a social situation	1.4
To keep from being bored	1.4
To be accepted by my friends	1.4

As a result of heroin use, the addicted women in this sample were bothered a lot because "people I know complained about my habit" (42.5 percent), and because "communication with my parents and family decreased" (52.1 percent). Although these things bothered the addicted women, their primary motives for entering treatment were "setting a bad example for my kids" (16.4 percent) and "starting to dislike myself" (13.7 percent). In addition to reasons for coming to treatment, the women were asked what caused them the most difficulty--a decrease in communication with their parents and family was one of the most important.

Can the addicted women in this sample "imagine or see themselves as being completely free of drugs"? The overwhelming majority (93.2 percent) said that they could. The addicted women in this sample also overwhelmingly felt (80.6 percent) that they would be drawn closer to their families if they were to become completely drug free.

CONCLUSION

The results of this research indicate that the drug treatment literature has grossly overstated the differences in the family dynamics of heroin users and nonusers. The differences in the psychosocial milieu of the families as demonstrated in this study are subtle rather than pathological, as has been presented in prior drug literature. This research would suggest that the family structure of addicted women is more heterogeneous than past studies might show. The addicted women in this sample were just as likely as the comparison women to be reared in a two-parent household. The comparison women were more likely to be reared with only a mother, while the addicted women were more likely to have lived with a mother and a stepfather. This research further indicates that a one-parent household is not more likely to influence later drug use. Gorsuch and Butler (1976) found that family intactness is only an indirect measure of many of the important family variables.

The addicted women were just as likely as comparison women to describe their family lives as happy while growing up. The families of both groups of women were also able to provide basic economic necessities of life and did not consider themselves poor. The conditions of the childhood of the addicted women were not marked by unusual poverty. The parents of both groups had jobs that would be classified as "blue collar." The parents of the addicted women were more likely to have only some high school education, but the majority were still able to provide a "steady income" for their families. The parents of the comparison women were more likely to have some college, but were not more likely to be on a better economic level. Somehow, the parents of the addicted women were able to build a stable economic environment for their families.

The descriptions of their family lives, the closeness of both groups to their parents and siblings in addition to the amount of time spent in large family groupings, would suggest that the women in both groups were reared in extended domestic networks. As children, both groups of women got together frequently with their families, including aunts, uncles, grandparents, and cousins. Gans (1962) and Berger (1960), among others, reported that residents of working-class communities were especially likely to be involved in kinship networks. Stack (1970), Meadow (1962), and Blumberg and Bell (1959) have also found that most blacks and other urbanites have relatives living in their vicinity, and that a majority interact with their relatives regularly. Feagin (1968) hypothesizes that "informal networks may provide an organized context in which many, if not most, ghetto dwellers are able to cope. . . ." It would seem that family solidarity and the stable neighborhood surroundings played a part in the creation of the relatively stable economic and home situations of these two groups of women.

In describing their parents, both the addicted and comparison women slightly favor their mothers, in contrast to the neurotic, dependent relationship characterized in the drug literature (Mason 1958; Chein et al. 1964; Wolk and Diskind 1961). In fact, both the addicted and comparison women perceive their mothers as being helpful, loving, strict people who were good mothers and easy to get along with. This research would suggest that the mothers of both groups of women played a central role in childhood. The mothers of the addicted women did not seem to reject their daughters after they became addicted. Wallace (1976) found that heroin-addicted women most frequently mentioned their own mothers as "the person I would miss most if they were no longer around." The mothers of the addicted women in this sample also continued to support their daughters after their addiction. More importantly, the mothers of both groups were seen as warm acting, relaxed, supportive parents, who provided a happy home situation.

Both groups of women were just as likely to see their fathers as being helpful, loving people, but were likely to have more positive perceptions of their mothers. The impact of sex-role identification and family ideals may also be operating in these perceptions. "Wives, mothers and sisters are all focal figures in American family life" (Cumming and Schneider 1966). Girls are also socialized to be like their mothers and consequently spend a great deal of time with them (Chodorow 1974). The women in both groups were more likely to say that they engaged in a variety of activities with their mothers than they did with their fathers. The father's role in the family has been underemphasized in American life, and it has only been in recent years that social scientists have paid some attention to his presence (Pleck 1975).

The women in both samples describe their fathers a little less positively than their mothers, but other indications of rejection by or rejection of the father are absent from this research. The

less positive descriptions of the fathers only serve to highlight the central importance of the mother-daughter relationship for women. It may also suggest that the women do not know their natural fathers as well as their mothers.

Socialization techniques and the perceptions of them during childhood differed for the two groups of women. Some of the addicted women felt they were punished "much more than other children," but a similar number of them felt they were punished "not nearly as often as other children." Neither group felt they were punished without reason while growing up, but the addicted women were punished and disciplined differently. The addicted women were more often made to do extra work, given a lecture on what they had done wrong, kept from going someplace or doing something, and were screamed and yelled at more often. However, the parents of the addicted women did not punish them physically any more than the parents of the comparison women. These differences, considered with the fact that addicted women in this sample were much more likely to run away from home, indicate discord in their family of origin during their adolescent years.

The attitudes and perceptions of their parents and family lives would suggest that the behavior of the addicted women when they were adolescents might possibly explain some differences in punishment and discipline. Besides running away from home, the addicted women were more likely to "hustle" money from adults, and were also more likely to go to a friend's home instead of a relative's when they did leave home. Drug use in general began before they left their families of origin and during adolescence. The first drug used for 25 percent of the addict respondents was heroin, and for 44.4 percent it was marijuana. The majority of the addicted women first tried heroin when they were between 16 and 18 years old.

The addicted women were more likely than the nonaddicted women to leave home before or around age 18. Drug use seems to be an important variable in the separation of the addicted woman from her family. It may also be related to the increased likelihood of the addicted women's leaving school without a high school diploma, since the overwhelming majority of the addicted women also viewed themselves as "good or average" students. The new friends and environment of drug users may have also influenced the addicted women in their decisions to leave high school. Although drug use was one of the critical differences in why addicted as opposed to comparison women left school, being pregnant or having children and being bored or tired of school were the most important reasons for both groups.

These data may provide some support for the Cloward and Ohlin (1960) theory that blocked aspirations lead to heroin use. Apparently, those who aspired to upward mobility and found their ways blocked were more likely to become addicted than those who did not have such high aspirations (Lukoff and Brook 1974; Kleinman et al. 1975). Possibly because that extra bit of encouragement from a special teacher was lacking for the addicted women or

because they began using drugs in high school, the addicted women lost interest in getting a diploma and instead turned to the adult world. Some may say the lesser educational attainments of their parents were the cause of their dropping out, but very few addicted women reported that the family was a reason for their leaving school.

The peers of the addicted women seemed to have greatly influenced them during adolescence. The addicted women in this sample indicate that "being around people who use drugs, being in that environment" was one of the more important reasons for their use of heroin. It is difficult to determine whether the hassles with their parents preceded their drug use or whether the addicted women's drug use in adolescence caused discontent with the family. For 13.7 percent of the addicted women, the third most important reason they used heroin was because of hassles with their parents. These addicted women thought highly of their parents and probably wanted to please them, but the lure of the drug lifestyle may have been overpowering.

The differential use of alcohol in the family of the addicted and comparison women may have been a factor in the hassles, disciplinary techniques, and the discontent that the addicted women expressed. The family members of the addicted women were more likely to "drink a lot." Interestingly, a large percentage of comparison women also indicated that there had been some problems in the family because a family member drank alcohol. The atmosphere often created in the home by excessive use of alcohol may have certainly influenced the addicted women's drug use. This research also shows that even though the comparison women's family members also had drinking problems, the addicted women were significantly more likely to perceive heavy drinking as a problem.

Heroin addiction arises from a complex interaction of powerful forces, and the family of origin of the addicted person has been identified as a significant factor. The role of the family in the later use of drugs cannot be diminished, but this research suggests that the notion of the multigenerational transmission of pathology in the families of heroin users is a myopic and inaccurate view (Carr 1975; Distasio 1974). Only subtle differences exist between the family lives of female heroin users and nonusers of the same socioeconomic background.

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CHAPTER IV

Implications for Treatment and Future Research

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This chapter will integrate some of the findings presented with an emphasis on treatment, service delivery, and program planning implications. Examples of activities and strategies that different programs have tried will be incorporated whenever they are relevant or useful. Finally, some key research issues and questions will be identified and discussed briefly.

INTAKE AND INITIAL TREATMENT SESSIONS

The lower self-esteem and higher levels of depression and anxiety reported need to be considered in early contact with addicted women. They may not feel that they are worth the effort of treatment, may have difficulty mustering the energy to participate, or may be very pessimistic about the possibility of positive change. Their anxiety can be a motivator for treatment as Colten suggests in chapter 1, or, if it gets too high, it can cause them to flee to a situation that feels safer. Thus, special techniques may be required to engage women addicts in treatment.

Build on strengths. Techniques that build on the strengths of these women and do not undercut them should be useful. Immediate educational and self-improvement programs may have some utility. Treatment strategies that focus only on the negative consequences of the addiction and force the woman to admit only her mistakes and shortcomings may reinforce the low self-esteem and depression. Assessment techniques that allow the woman to identify both the positive aspects of her life as well as the problems may help keep some balance. Allowing her to express negative views of herself, her anger at the world and herself, and her sadness, while expressing concern for her as a person and optimism for her future, may be helpful. Specifically, the staff might focus on helping the woman (1) identify her self-expectations (both realistic and unrealistic), (2) develop

strategies that will help her recognize that many people have difficulty fully living up to their expectations, (3) identify the realistic choices that she does have available to her, and then (4) take responsibility for making and carrying out those choices with the support of the treatment program. If she is unable to make contacts with appropriate community agencies, then program staff may need to assist her in acquiring services, including accompanying her until she is able to do this for herself.

Use problem-oriented approaches that can also build skills and confidence. The data suggest that a practical, problem-oriented approach would be useful and most acceptable to the drug-dependent woman. Women (and men) entering drug abuse treatment report exchanges of practical help with their friends rather than the emotional support reported by the women not involved with drugs. Those entering drug treatment also do not seem to use community agencies and other sources of services as much as the level of their problems suggest they need. In Detroit, 26 percent of the addicted women versus 11 percent of comparison women reported that they go to "no one" for help with health problems; for family problems, 29 percent of addicted women and 21 percent of the comparison group reported going to no one. Help in a treatment program is also likely to be seen as something tangible; immediate attention to reality problems and other possible sources of anxiety and depression are important.

The woman's concerns about what may happen during treatment should be elicited and addressed realistically. Even if problems cannot be addressed directly, this approach indicates staff awareness and concern for those areas the addicted woman sees as problems or potential problems. If there are severe or interfering medical, family, or other social problems present, the woman may not be able to work on drug-related issues without attention to these other areas as well. Individual or group therapy may have little salience for women clients until the reality problems are stabilized and it can be demonstrated that working on emotions and interpersonal relationships can be useful. Even then, more structured strategies with more immediate and observable effects may be necessary. If possible, early activities should be those that will attend to some of the immediate problems while teaching coping behaviors and the value of interpersonal support, i.e., self-help groups or problem-focused rap or educational groups.

Move slowly on relationship building. Compared both to men and to the comparison women, the drug-dependent women report that they are lonelier and more isolated from meaningful and nonstressful relationships with others. They seem to interact with those persons available to them in ways less likely to promote helpful emotional coping, a fact which will certainly affect treatment throughout, but which has special implications early in the treatment process. Staff members may have to reach out repeatedly, since these women are used to coping by themselves. Staff may be rebuffed initially, even frequently--perhaps because the woman has learned to be defensive, but also because she is likely to behave in ways that will confirm her negative opinion of herself and cause others to react to her the way she expects them to.

At some point, of course, the program will want to help the woman develop relationships that are supportive of her efforts to change, but if the woman entering treatment is vulnerable and ambivalent about closeness, as the data suggest, a slow, cautious approach to relationship building may be advisable. Pairing the client with a woman who is having some success in treatment and who can assist her through the early stages of treatment is one possibility. Active coaching by staff or treatment-wise clients would be another. Whatever the strategy (which must vary depending on the design and goals of a given program and an assessment of each woman's strengths and needs), consistent acceptance and firm efforts to draw the client into treatment will demonstrate that the staff considers her worthy of attention.

Pace and plan interventions carefully. Adequate pacing of interventions is probably the key to success. Some women will obviously be able to move more quickly than others. Women's higher levels of discomfort at treatment entry can work as motivators if the program bolsters the woman's self-esteem and does not move so quickly that the anxiety and/or depression become overwhelming.

A nonpunitive attitude is particularly important. For women already anxious, depressed, and down on themselves, being made to feel guilty will not be useful. Workers may need to contact women clients more often outside of the treatment program, especially early in treatment if clients start to miss appointments. Identifying possible barriers to treatment will be very important. If child-related, family, or health problems or some dissatisfaction with the treatment program are interfering with the woman's ability to commit herself to treatment, staff may be able to help make arrangements to allow her to continue. At the same time, reaching out to her will demonstrate the program's interest in and commitment to her.

None of this is meant to imply that staff should coddle the woman or allow her to "get away with murder," as this might convey an attitude that she is too "weak" to handle program stresses. Clear and consistent explanations of what is expected and the consequences of violations of these expectations should be part of early phases of treatment. The program should examine thoroughly, however, the nature of these expectations, the types of interventions used with women to assist them in dealing with drugs and other problems, and the types and pervasiveness of program support.

NECESSARY SERVICES

All of the practical problems more often reported by women, coupled with their lower self-esteem and fewer numbers of resources, suggest that services usually designed to augment basic counseling services are, in fact, likely to be essential if programs wish to intervene effectively with women. Not only will

these practical, reality-based problems interfere with treatment efforts if not addressed, many ways of addressing them can also be learning and growing experiences for the women in question.

There are advantages in the program's seeking these services elsewhere, although the process will probably be frustrating and time consuming. One advantage is the augmentation of the resources of the program. A second is that the client can learn to seek resources from a variety of institutional and other support systems on her own. This experience and the skills associated with it should serve to decrease the woman's dependence on the drug treatment center as a source of all necessary services and allow her to survive more effectively.

The data indicate which services are essential for women. These services are useful and sometimes essential for men, too, but they are likely to be even more important for women.

Health care. In this study, women report more health problems than do men. Another WDR study (Andersen 1977) suggests that in general women receive less comprehensive medical services from drug treatment programs at all stages of treatment, partly because gynecological services are not available within the program. Andersen's data also suggest that women's health problems, compared to those of men, worsen with induction into treatment programs. Thus, more active health care systems may be necessary when treating drug-dependent women.

At a minimum, programs need to require regular Pap tests and gynecological exams. The level of dysmenorrhea is high among drug-involved women, and they are at risk for cervical and uterine malignancies, as well as many other gynecological problems/infections (Gossop et al. 1974; Santen et al. 1975; Stoffer 1968). Other possible strategies include--

- Self-help groups. These groups would teach women about their bodies, about how to examine and take care of themselves, etc. Women would assist each other in learning about basic health care and relevant health-related practices for themselves and their families. Many women's centers use such groups and should be able to help staff or more advanced clients learn how to run such groups. If the program has a nurse s/he might be the logical person to facilitate such a group, or perhaps a volunteer could be located. Books such as Our Bodies, Ourselves (Boston Women's Health Collective 1973) would be invaluable resources, not just for this group, but for the program and the women in general. These groups are not only educational, they also give women much more understanding and control of their own bodies, and therefore increased self-confidence. The women are likely to become more assertive and knowledgeable consumers of health care, and they should be more able to promote better health and more effective health problem solving within their families.

- Regular checkups. Free medical and dental clinics are usually available in metropolitan areas. Regularly scheduled visits that are part of progrm expectations (and may be initially program facilitated) should help develop sound health practices. In conjunction with these visits, women should be taught to be appropriately assertive with medical personnel. Such visits may also begin to decrease the crisis-oriented approach to medical issues that is common among addicts.

- Medical resources. Visiting public health nurses may be available to assist clients at home with medical or health issues, or to run classes or clinics at the agency. Health fairs (in which a variety of medical information, diagnostic procedures, and basic services can be available at once) can be conducted onsite. These take considerable planning and coordination, but often volunteers or consumer groups concerned about health care will assist or plan them completely. Check with nearby medical, nursing, and dental schools about the possibility of placing students at the facility. Not only will this increase the services available, but it will also provide student health care professionals with experience with addicted populations, so they may have fewer stereotypes about, and more knowledge of, the types of problems found among addicts when they begin practice.

- Special classes in areas of concern. Courses on reproduction and birth control, nutrition, child health problems, and other areas related to individual and family health may all be attractive to different groups of women, and will build relevant skills and confidence. Volunteers or clients (patients, residents) themselves can be recruited to offer such sessions.

Child care and addressing child-related problems. Seventy-three percent of the addicted women in this study have children. They were more likely than the comparison women to have children and less likely to be married or otherwise involved with a supportive partner or best friend. The women with children entering treatment were heavily dependent upon their mothers for child-care support; perhaps women without such support do not enter treatment. They also seemed to have children older than those of the comparison-group women; perhaps women with younger children are less able to enter treatment. Compared to men entering drug abuse treatment, they were much more likely to continue to live with and be responsible for the care of their children. Approximately 30 to 40 percent of these women had children living elsewhere (usually with relatives).

The responsibility for children seen in the addicted woman suggests that treatment efforts will have to take into account that added concern. Her children may be the most meaningful part of her life and the strongest motivation she has to get off drugs (Milstein et al. 1971; Eldred et al. 1974). Thus, attention to child services can serve at least three purposes: (1) to facilitate the mother's involvement in treatment, (2) to assist her in performing her parenting roles more effectively (or in making other

responsible arrangements for her children), and (3) to minimize the destructive impact that her addiction may have on her children.

Services for children currently available in programs vary widely. Residential programs may, at a minimum, help with child placements and facilitating visits with the child--either within the program or elsewhere. Short stays within the program are more common, and, increasingly, programs are allowing the children to live there. Models for this range from the mother's maintaining full responsibility for the child, to program-sponsored day-care staff coverage, to full-time nurseries and separate children's living quarters with full-time staff. Many programs that emphasize care for women are beginning to define this contact with children as a right, not a privilege to be earned. These programs are beginning to describe some of the management issues that arise from having children in residence (Schwingl et al. 1977; West et al. 1978), and those considering this step should consider these implications carefully.

With respect to outpatient treatment, program-sponsored day-care arrangements, at least while the woman is involved in program activities, are felt by many to be necessary for some women to seek treatment although onsite day care requires space, equipment, staff time, and maybe special licensing. Arrangements with existing day-care centers are another possible option, although few programs report such arrangements. Many programs report frustration that even when job training and educational activities are available for women clients, inexpensive and responsible day-care options are not, which makes welfare almost inevitable for so many women.

The types of help that women may need with their children may be extensive. Some may need help in securing welfare benefits and adequate clothing and equipment for their children. Nearly half of the addicted parents in the sample described here reported child health problems in the month preceding the interviews; discussion of the options available for resolving these physical difficulties as well as the development of problemsolving skills in this area may need to be provided. Parents with school-age children may need help in maintaining appropriate contact with the teachers and in coping with school problems in their children. The program may also be in a position to make arrangements for care of the children if the mother needs some time for herself, or faces incarceration.

Some programs are involved in active and often extensive parenting training programs, as well (Lief 1976; Finnegan 1979). Community resources may be available to assist in or even provide staff for such endeavors. Child and family agencies, other service agencies, and some school districts have staff who are likely to be knowledgeable about child development and parenting issues. Drug program staff may need to work with outside resource people to be sure that the content and style of the training sessions are compatible with the needs and backgrounds

of the interested clients. Another strategy the program might adopt is to facilitate parent exchanges through child "drop in" centers where isolated women may get together to socialize, share child-care responsibilities, and gain new ideas on ways of interacting with developing children.

The drug treatment program is in a good position to provide support and help the woman obtain additional supports. It can also provide parenting training and sound knowledge of child development to help the woman develop realistic expectations about her child and its development.

Homemaking skills and other training in practical and more creative concerns. Given the fact that so many women entering drug treatment have children and are more likely to value the more traditional female roles, training in a variety of homemaking skills may be very useful. Budgeting, nutrition, hygiene, planning and preparation of inexpensive meals, utilizing available social services, and negotiating a number of key societal institutions (schools, insurance companies, etc.) are all subjects and skill areas that would be very useful for these women. They would have immediate impact on the family and should also help to promote feelings of greater competence and more control over one's life.

Many other skill areas (e.g., sewing, photography) could also have practical utility, increase self-confidence, and could become useful leisure-time and expressive activities for women who, until entry into drug treatment, may have spent much of their time hustling drugs. Some skills might even lead to future employment. Some programs feel that sessions in dress, appropriate makeup, hair styling, etc., can be very useful, especially for those women who are trying to make transitions into very different lifestyles or for whom an improved appearance would bolster generally low self-esteem.

Since very few programs can afford staff who can conduct programs of these types as a major part of their work, most who utilize such activities rely on volunteers, clients willing to share skills, or staff members who happen to have skills in a given area other than the one they were hired to perform. Various craft associations, service clubs, and industries may donate used equipment and train clients in its use. Sometimes space and equipment will be available in a local facility that does not get full-time use (churches, for instance). In some communities inexpensive continuing education classes are offered by schools in a variety of areas. Where programs can guarantee specific numbers of registrants, such classes may be able to be offered at the treatment center. All of the above may not require much money to develop, but will take some staff or resident/client time, creativity, and resourcefulness.

Education/employment skill training. While comparison women were more likely to drop out of high school because of academic difficulties or money problems, addicted women were more likely

to be bored and tired of school. Once these women come off of drugs, it may be necessary to pose career options so that clients are not left facing another life situation that lacks sufficient meaning or excitement. Even more important, work will be a financial necessity in most cases.

Treatment should thus include programs enabling clients to obtain high school degrees (e.g., GED); acquire basic skills (e.g., reading, writing, and mathematics); and gain useful, marketable skills. Counselors can facilitate this in a number of ways. They may, for example, try to get several clients involved in training programs so that they can hire a part-time, or even full-time, teacher if enough students are seeking GED certification.

In addition to basic education, female addicts require employment services. Workshops may be designed around ways of obtaining jobs, such as interviewing skills. Given their feelings of lack of competence and self-esteem and their lack of previous job experience, women addicts may experience difficulty and doubt in the course of pursuing educational goals or even after obtaining a job. Doubts and fears may be further exacerbated by a lack of friends in the straight world with whom women addicts may identify and obtain support. The program must then be prepared to support women clients in their efforts to make a place for themselves. Women's centers and agencies developed to assist women into the workplace may have some useful services.

Recognizing skills already or once possessed. Treatment personnel should help clients begin to recognize and assess skills that they already possess, but which may need to be redirected for participation in the larger society. For example, the tactics that enable one to obtain drugs may not be the same strategies that one would use in dealing with social agencies, but some of the skills may be similar. Clients (and staff) must learn to recognize and value these skills and develop ways to translate them into new and more useful forms to accomplish new tasks and lifestyles.

Group sessions in which the women help each other identify what they did well prior to entering treatment (whether legal or illegal, major or apparently insignificant) would be useful. These activities should be broken down into the skills necessary to accomplish them. Then, attention must be given to the application of these skills in the straight world, how they must be modified, and what new skills must be learned. An approach such as this allows the client to begin to see and value the resources she already has rather than simply being overwhelmed by the changes she must make.

Fostering independence. One of the differences between addicted and comparison women that emerged in this research was that addicted women described themselves as needy and incapable, i.e., they see themselves as needing more from their partners and contributing less to the relationship. This is likely to be the attitude with which they approach the treatment center as well. An approach which involves only the center's taking the

responsibility for helping the client meet practical needs has the potential danger of reinforcing this self-definition.

The program can adopt a number of strategies to prevent clients from becoming too dependent on it. In general, any strategy which helps the woman to learn to plan for herself or which allows or insists that she learn to deal with situations and problems more effectively on her own should leave her with more supports and resources after formal treatment ends. The center may act an an advocate for the client, but the focus should be on the woman doing for herself, with appropriate program help: information, procedures, training, and enough support to insure her success. Some programs have accomplished this by having clients create and modify their own treatment plans with staff advice and support. Others have trained women to do advocacy work, both for themselves and for other clients. A third example involves using assertiveness training and active support from other women to assist the woman in coping with confrontation sessions.

Augmenting or revising confrontation strategies. Public confession and recognition of one's inappropriate behaviors is often considered an essential component of the treatment process, as indeed it may be if one continues to avoid facing the consequences of destructive behaviors. For women, however, such an approach may perpetuate the harsh judgments these women already make about themselves and may undercut the very strengths they need to rebuild their lives.

The research presented earlier suggests that addicted women share the negative views that others have of addicted women. They already express feelings critical of themselves. Confrontation strategies alone, to the extent they tend to disparage the individual and focus primarily on failures, are likely to perpetuate feelings of failure and self-blame. The addicted woman may feel she deserves this treatment; but in the long run it is unlikely to lead to improved self-esteem or more effective coping or problem-solving.

Where there is denial, manipulative behavior, or a self-serving misperception of events, challenging and refusing to accept these behaviors is, of course, essential. These must be a part of a wide range of techniques used, however, and not the sole focus of treatment. For the drug-involved woman, decreasing the excessively harsh judgments that she makes about herself may be far more important. She must learn to develop a more flexible and tolerant view of and expectations for herself.

Possible strategies to build self-esteem include some mentioned earlier, e.g., training in assertiveness for women so they are better able to defend themselves realistically in confrontation sessions. Active sports programs can help the woman gain confidence and pride in her abilities, become more aware of her physical needs and strengths, and learn how to accept and manage competitive feelings. These physical activities also are likely to

take advantage of the positive body image expressed by these women.

Programs also need to recognize and build on the other areas in which women have special strengths. Women, in comparison to men, are more likely to be open about their feelings and to have more developed interpersonal sensitivity and skills (Chodorow 1974). These data suggest that drug-involved women are, in fact, more aware of and expressive of feelings than men but see this as a liability. Treatment programs need to find ways to help women use their more developed emotional expressiveness in treatment and begin to value it. Craft and other creative activities can have this effect. Dance, drama counseling, and poetry therapy can also help women identify and express important thoughts and feelings and to value them.

Addressing sex-role issues. Several issues involving sex roles have emerged from this research: (1) Addicted women, perhaps even more than other women and addicted men, have learned to value male and devalue female roles and behaviors; (2) they may feel there is a barrier between themselves and "normal" women because of their addiction; and (3) their pictures of appropriate models of masculinitiy and femininity seem to be unrealistic, given their overall life situation. They share with nonaddicted women a view of men as more easily hurt and more in need of being cared for than women, but feel they must be dependent on men in order to survive. They also view women as being more misused in this society.

Treatment should include education about how women express symptoms and cope differently from men (Gove et al. 1973) so that they can accept their own style and consider alternatives. Areas that often cause problems for women should be recognized by staff and addressed in therapy: assertiveness, independence, competition, and gaining control over one's life. It should be recognized that many of the inadequacies felt are a result of trying to master multiple roles (e.g., parent, helpmate, worker, daughter) without receiving short-term rewards from many of them. An awareness of possible role options and alternative opportunities should be fostered.

A most important component in treating women is the relationships among women. As women learn to like and respect other women more, not only will they develop more sources of emotional support and friendship, they will also begin to like themselves as women more. Building support groups and stressing some of the similarities among women in the program is one strategy. Using female role models on the staff and as volunteers is another. Female counselors who are sentitive to women's issues may be very important at some stage of treatment. Having some women in positions of power within the agency is also important role modeling--demonstrating that women can achieve respect and competence in work settings. Developing links with women's groups and activities outside of the drug treatment program may also be helpful.

Attention must also be paid to male-female relationships. Staff may have to modify some of their own preconceptions about appropriate male and female behaviors and roles. Active staff modeling of nonstereotypic ways that men and women can relate will be important. How female and male staff behave toward each other will be more important than what they say.

Training and supervision of all counselors should include education about sex roles and their impact. Programs may also need to seek outside consultation to assist them in maintaining an atmosphere that does not inadvertently support sex-role stereotypes. Most of the behaviors and attitudes are so entrenched that many men and women may be entirely or partially unaware of them or how they can manifest themselves (Broverman et al. 1970; Doyle and Levy 1975; Ponsor et al. 1974; Edwards and Jackson 1975).

Finally, the question of the therapist's sex must be addressed. The women in treatment (along with the nonaddicted women) feel that men neither take them seriously nor respect them. They may even have been physically abused by men in their lives. This may make it more difficult for them to be treated effectively by a male counselor, especially if his own training has not included an awareness of sex-role issues and an identification of his own particular attitudes and reactions. Probably, given the reality of male-female reactions today, at least some portion of treatment needs to be conducted for the women alone. Some of the issues that women need to explore will not be explored in the same way with men present. Programs which do not have staff available to conduct such activities may be able to recruit some volunteers or to hire a consultant who can work with the clients, and also train appropriate staff. At the same time, the program needs to be concerned about gender issues for men, and women's relationships with men. This may be accomplished within program activities or by working with the woman and the man or men important to her. Again, an awareness of various role options and alternative opportunities should be fostered.

Implementing family-oriented strategies. Where relevant, couples-therapy strategies may be necessary to assist partners to support each other in the changes necessary to give up drug use. Since the male partners of addicted women are likely to be involved in drug-related activities, the involvement of both partners will be even more important when considering the treatment of women. This type of involvement, in a sense, represents the ultimate expression of support for the other's treatment effort and may lessen the possibility of either's slipping back into drug use. Such treatment also allows both parties to explore their relationship and the conditions relevant to both their lives that foster drug use.

The program may also want to involve children and/or other key persons (e.g., members of the family of origin, or other blood-related or important people in the woman's life) in order to develop and strengthen positive supports and to intervene into more destructive dynamics. Care must be taken not to define family

solely in terms of the nuclear family, since many of these women have broader and more extended family support systems.

Creating new sources of support. Especially since women tend to be more attuned to and affected by the nature of their interpersonal relationships, the loneliness and relative social isolation reported by these women should be a major focus of treatment. They need to learn to rely more on others to assist with emotional problemsolving. If a woman is involved in a close relationship with someone who is not supportive of her efforts to change (many report that their partners are also involved with drugs), the program may need to assist her to sever that relationship if she wishes to. New and more helpful relationships may be necessary for many women if they are to maintain a new lifestyle. Some new interpersonal relationships can be developed within the program, while others may depend on community resources, groups, and institutions.

Within the program, many of the activities described earlier will assist women with similar interests or problems in locating each other and participating in similar activities. Women can be encouraged to consult with each other in problemsolving activities. Tasks can be undertaken in groups; several people can take trips to medical facilities together; recreational and skill-building activities can be done together. "Buddy" systems, in which women are paired and are responsible for each other during treatment, seem to be useful in some situations. Women further along in treatment may be particularly helpful to those just beginning treatment and will learn useful skills in the process.

In counseling, women should be asked to explore the nature of their relationships and how they interact with others. Role playing and other strategies in which they can learn to put themselves into others' positions should be encouraged. Examination of how they cope with anger, disappointment, and other feelings can be followed by discussions or role plays about possible alternatives.

In addition, contacts can be made with groups and activities outside the treatment program to help drug-involved women see that at least some of their problems are common to all women and are not just a result of their own incompetence or unworthiness. Single-parent groups, job-readiness training, action groups dealing with inequalities between women and men in salaries, etc., are possible examples. Such contacts should also help provide some transition as the woman approaches the end of treatment.

Termination of treatment. If the women and men in these studies are typical of those in most drug programs, very few will complete the entire treatment program as it was planned. Most will drop out before staff feel they are ready or will be terminated for program violations. Many are likely to come back to the same or different programs and may progress a bit more in each treatment attempt (Sells 1974). Some will, of course, complete the program and will need to be assisted through some sort of transition to a life without drugs or the support of a drug program.

Few studies have specifically investigated women who are successful at completing programs, nor have any patterns of "splitting" and returning that are particularly female been identified. When significant others (especially family) continue to treat the recovered individual as though s/he were still an addict, a relapse is more likely (Waldorf 1970; Ray 1964). Given that women are more likely than men to rely on interpersonal relationships for support, these relationships may have an even more important influence on women. Eldred and Washington (1976) found that significant numbers of women were living with heroin users during all attempts at their own withdrawal.

Whatever else the drug program is able to do, it should assist the woman to assess her situation accurately. Anticipating potential problems while still in the program will allow the woman to practice appropriate problemsolving and coping strategies in preparation for termination. The program may also need to assist in making new living arrangements and in strengthening relationships outside the program to replace those they will be losing within the program.

Some residential programs are assisting their residents to find living quarters that they can share with each other. Program staff help graduating residents locate appropriate housing, and assist them in planning to live together--identifying key tasks that need to be accomplished and developing ways of sharing these tasks. Buying and cooking food, providing child care, obtaining money for the household, doing the housework, etc., must all be addressed. These kinds of situations are particularly useful for women, since those who wish to stay home can tend to the children of those who wish to work and can find a job. Having several adults in a living situation--if all are concerned about the welfare of the children--greatly increases the likelihood that a child can find someone to relate to and decreases the potential for neglect or abuse. Program staff may be called upon to assist in problemsolving or to intervene should a crisis develop, and may wish to stay in close touch until such arrangements have stabilized into workable procedures. If all the residents are willing, these situations can also be visited by persons still in treatment, or they might act (however briefly) as halfway houses for those preparing to leave treatment.

Whatever support systems are being developed, particular attention should be paid to child-rearing and child-care issues. Babysitting exchanges and continuing parenting classes, for example, could be used as alternative sources of ongoing support.

Clients who are terminating can be linked to those who have already made the transition successfully for help in identifying potential problem areas and ways of handling a variety of situations encountered by "ex-addicts."

Volunteers and volunteer groups can be used to help people get reestablished. Service groups, church groups, and the like may be interested in long-term work in conjunction with the treatment program.

Finally, the program should work closely with self-help groups in the community and encourage terminating clients to establish links with them. Narcotics Anonymous provides one model for this kind of support system. If appropriate groups do not already exist in the community, the program could start one for its clients.

FURTHER RESEARCH

These papers present information about addicted women in areas not often studied in addiction research, areas that are known to be important for most women, both in determining behavior and in supporting behavioral change. These include the attention to support systems, both interpersonal and institutional, coping styles, and sex-role attitudes and values.

A number of the most immediate research needs to be mentioned, e.g., exploration of racial and cultural differences, and a need for longitudinal studies, can begin to investigate the characteristics, events, etc., that might be considered to be antecedents of drug use/abuse and those that, by the time of admission to treatment, seem to be largely consequences of drug involvement. We know very little about the progression of drug use in men and even less in women. While the distinction between antecedents and consequences is considered by some to be less important by the time a woman enters treatment (the needs and dynamics are present and must be dealt with no matter what their causes), understanding more about the causes and process of addiction would help to determine what intervention to choose and, more importantly, how to prevent problems with drugs. Several other key research areas that emerged are given in the following paragraphs.

Pattern at the time of entry to treatment. What factors affect the decision to enter treatment? What strengths and problems do women bring with them into treatment? Particular attention should be paid to key events occurring before the decision to enter treatment: the pattern of relationships, resources, and any change in those patterns, etc. Study could also explore staff's expectations about feminine and masculine behavior, and what they might be doing to precipitate inappropriate behaviors.

Progeny of addicts. Are these children more at risk for neglect and abuse or behavioral dysfunction? If so, in what ways and under what circumstances? This is an area that has received attention but that has not been investigated with appropriate comparison groups and procedures. What factors seem to be operating when there is no abuse, and what are the implications of these for prevention? What interventions can a program provide to stop or prevent abuse, or promote more effective parenting?

Treatment program evaluation and treatment issues. What sources of referral and recruitment might better attract women who could benefit from drug treatment?

What factors allow programs to retain women once they have entered? What is the split pattern for women? How does it differ for men? What causes them to leave? What helps them decide to come back?

What services, if any, are more essential for women than for men, and what services are less essential? What is the effect of differing models of service delivery?

How can a program intervene most effectively into a woman's relationships, either to minimize the effect of those that seem to be destructive or to strengthen or develop those that are supportive of positive coping efforts? How, and in what ways, might these strategies also be useful for men?

In what situations, if any, does the sex of therapist make a difference? How is it related to program stage, style, and sensitivity to sex-role issues, issues with which the woman must cope?

What types of counseling are most useful with women? Do, in fact, straight confrontation strategies have negative effects? What is the most effective way to modify them? What kinds of staff training are necessary?

What skills, supports, and services are necessary to assist in the process of terminating from the program? What causes some women (and men) to relapse? Are these factors different for women and men? If so, how, and what are the program implications?

All of the above will affect program design and management strategies. Those involved in providing service to both women and men must be willing to develop models to test key assumptions, and systematically to evaluate different approaches. These data and other research results are beginning to define key differences between women and men entering drug abuse treatment. Further research will need to address the implications of these differences.

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